DIFFERENCES IN THE EXPRESSED COPING STYLES BETWEEN THE HUSBAND AND WIFE WHEN THE WIFE IS TERMINALLY ILL

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ABSTRACT

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In the present descriptive study differences in Coping Style (Total) between twenty husbands and wives when the wife is terminally ill were identified. Coping Style (Total) is composed of Behavioral Coping Styles and Cognitive Coping Styles. Therefore, the differences in Cognitive Coping Styles and Behavioral Coping Styles between husbands and wives were also determined.

To determine the differences between the mean scores of Coping Style (Total), Behavioral Coping Styles (Tackling and Capitulating), and Cognitive Coping Styles (Vigilant Focusing and Minimization) of husbands and wives the t-test for small sample means was used. The findings suggest that there was no significant difference between the Coping Style (Total) and Behavioral Coping Styles of husbands and wives. The findings further suggest that there was a significant difference between the Minimization Coping Style of husbands and wives.

To My Beloved Tim

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CHAPTER I

THE PROBLEM

Introduction

The human capacity to cope with pain and suffering of severe physical disease appears to be immense. Individuals continue to function under the most harrowing life circumstances (Moos 1977). Why don't they simply give up under this stress? What are the coping styles which facilitate effective recovery? Are these coping styles similar to the ill individual's members? This study is an attempt to discover the coping styles that husbands and wives utilize when the wife has a terminal illness. A conceptual framework will be presented to demonstrate the psychological healing process of both husband and wife to a stress. Implications of nursing interventions to facilitate this process will also be presented.

Crisis theory has made a substantial impact on the understanding of how individuals cope with major life crises and transitions. Crisis theory has provided a conceptual framework for preventive psychiatry in general, and for handling severe physical illness in particular. Lindemann (1944) gave impetus to this field with his vivid description of the role that community members have in helping bereaved family members cope with the loss of their loved ones. Lindemann's work, as well as Erikson's formulation of "developmental crises" in the life cycle, paved the way for Caplan's classic formulation of crisis theory (1964).

Similar to the individual's need for physiological homeostasis is the requirement for a sense of social and psychological equilibrium (Moos 1977). Generally, individuals have certain characteristic patterns of behavior that they employ to problem solve situations. However, when a situation is so novel that the usual responses are inadequate to restore balance a crisis occurs. Hill (1964) defines the crisis state as an overwhelming situation in which the individual has not had previous experience, nor the appropriate resources available to effectively cope. The crisis experience may be viewed as a transitional period, a time for personal growth and maturation, or a maladaptive response leading to psychological decline. This transitional period has important implications for an individual's ability to meet future crises.

Severe physical illness almost always represents a serious upset in an individual's equilibrium. A person may face the loss of key roles in his or her life, changes in appearance or bodily functions, assaults on self-image, helplessness, anger, anxiety, and an uncertain, unpredictable future (Moos 1977). At a time of disequilibrium, the individual is much more receptive to outside influence, according to crisis theory. This period of receptivity offers those in the nursing profession an opportunity to have a strong constructive impact on the lives of individuals in crisis. The crisis of illness may extend over a long period of time. The ill individual as well as all family members is presented with a set of new issues with which they may have had little experience. It is essential that individuals with a severe physical illness and their family members or spouses cope with this threat in order to reorganize and achieve a new equilibrium. Continued family functioning is not possible without this reorganization. Traditionally the family unit has been the primary support system when one of its members faces a crisis (Giacquinta 1977). However, the family itself may be considered in crisis when one of its members is facing the threat of impending death due to a terminal illness. The crisis is not only viewed as a personal tragedy, but as an assault on the integrity of the family unit as well.

Assuming that a terminal illness constitutes a life crisis, it is essential that the individual cognitively appraise the significance of this crisis prior to the selection of appropriate coping styles to carry out necessary tasks. Cognitive appraisal, the perception of the tasks involved, and the selection of relevant coping styles are influenced by three sets of factors or determinants of coping. These factors are intrapersonal, environmental, and illness-related. The following, adapted from Lipowski (1970), emphasizes the multifactorial nature of an individual's psychological response to illness:

Intrapersonal factors are those characteristics such as age, personality, intelligence, values, beliefs, emotional state, and cognitive capacity at the onset of illness and throughout its duration. A person's ability and mode of coping also depends on the timing of the illness in the life cycle. Intrapersonal factors all contribute to the subjective meaning the event has for the individual, and this in turn helps determine the coping style.

Environmental factors pertain to how both the social and the physical surroundings of the sick individual influence the mode of coping with the illness. Further discussion of environmental factors as they relate to the family is presented in Chapter II.

Illness-related factors include the type, location, rate of onset and progression, degree of reversibility, and other aspects of the pathological process which determine the effectiveness of coping. Illness-related factors not only influence the magnitude and character of the tasks imposed by the illness but also affect the meaning or significance to the individual. The more the impaired body part or function involves the individual's values, conflicts and sources of gratification, the more it challenges his coping resources.

These three major factors--intrapersonal, environmental, and illness-related--determine the outcome of the crisis. It is again noteworthy that family members and friends, as well as the ill individual, are affected by the crisis. These significant others encounter many of the same or closely related tasks, and use the same types of coping styles (Moos, 1977).

The purpose of this study, then, is to describe similarities in coping styles between husband and wife, when the wife is terminally ill. Caplan (1964) maintains that individuals experiencing a life crisis are more susceptible to external influences at that time than they are during periods of more stable functioning. Outside intervention can play a significant role in facilitating effective coping. It is especially important that members of the nursing profession recognize the opportunity to aid individuals and families in crisis.

Nursing literature has contributed very few strategies for facilitating the family, and more specifically the marital dyad, through the crisis of a terminal illness of a spouse. My experience in an oncology clinic has emphasized the need for assessing not only how the ill individual copes, but the spouse as well. By understanding the nature of the crisis as experienced by the husband and wife, and appreciating that there are characteristic patterns in which they cope, the nurse will be able to more effectively support and guide the husband and wife to acquire coping styles that will restore organized family functioning.

Statement of the Problem

What are the differences in the expressed coping styles between the husband and wife when the wife is terminally ill?

Hypothesis

There is no statistically significant difference between the expressed coping styles of the husband and wife when the wife is terminally ill.

Operational Definitions

Coping Styles

Coping Styles are the predominant use of certain defense mechanisms as well as manifestations of the individual's cognitive and perceptual styles. Coping styles may be evaluated as effective or ineffective depending on its appropriateness to the individual's age and situation, as well as its effectiveness in achieving maximum possible function or compensation. Coping styles are influenced by an individual's perception (cognition) and action (behavior) in response to a stressor (Lipowski, 1970).

Cognitive Coping Style

Cognitive Coping Style is an individual's characteristic way of perceiving, thinking, and problem-solving in response to illness. Vigilant focusing, and minimization are examples of cognitive coping style (Lipowski, 1970).

Vigilant Focusing connotes a brisk response to perceived signals of danger and persistent attempts to reduce uncertainty and ambiguity about all aspects of illness. Obsessional, anxiety-prone, or intellectualizing individuals characteristically use vigilant focusing. Vigilant focusing can be viewed as a continuum, ranging from hyper-vigilance or exaggeration of all threats to bodily integrity, to realistic recognition of threats and tasks and rational planning (Lazarus, 1974).

A cognitive coping style, vigilant focusing is operationalized by the following items on the Coping Index. The parentheses () refers to the husband's responses on the Coping Index.

> I actively seek more information about my cancer (my wife's cancer).
>
> I confront the doctors to answer my questions concerning my illness (my wife's illness).
>
> Things would be a lot better if my family and friends would talk openly with me about my cancer (my wife's cancer).
>
> Things would be better if the doctor would talk with me <u>more</u> about my illness (my wife's illness).
>
> Things would be better if I knew where I could get financial help.
>
> My husband (wife) and I should get professional counselling.

<u>Minimization</u> is the tendency to ignore, deny or rationalize personal significance of information input related to one's illness and its consequences (Lipowski 1970). Minimization implies a continuum of cognitive disposition, ranging from total denial to reasonable doubt. A cognitive coping style, minimization is operationalized by the following items on the Coping

Index. The parentheses () refers to the husband's responses on the Coping Index.

> I laugh off everyone's concerns about my health (my wife's health).
>
> I try to forget I have cancer (my wife has cancer).
>
> I spend time at little tasks to keep me from thinking about my illness (my wife's illness).
>
> There is something good about having cancer (my wife having cancer).
>
> I reduce tension I have by overeating, overdrinking, and/or excess drug usage.
>
> I will soon be just as good as before (my wife will be).

Behavioral Coping Style is the habitual mode of acting in response to illness. Predominant action tendencies may be altered by factors inherent in the individual's current psychological state and by other situational variables. Tackling and capitulating are examples of behavioral coping styles (Lipowski, 1970).

Tackling

Tackling is adopting an active attitude towards challenges and tasks posed by illness or disability. At one extreme of tackling coping style one encounters a tendency to "fight" at any cost (Lipowski, 1970). Tackling, a behavioral coping style, is operationalized by the following items on the Coping Index. The parenthesis () refers to the husband's responses on the Coping Index.

> I talk with friends and family members about my cancer (my wife's cancer).
>
> I follow my doctor's orders (encourage my wife to follow the doctor's orders).
>
> I work out good alternatives to some of my plans affected by my cancer (my wife's cancer).
>
> I look forward to the future.
>
> I will fight my illness any way I can (my wife's illness).
>
> I can look forward to more good times than bad (with my wife).

Capitulating

Capitulating is passivity, and either withdrawal from or dependent clinging to others. Individuals displaying this coping style show little observable initiative or action to combat illness and achieve maximum possible recovery. Capitulating is not to be confused with willing acceptance of periods of relative inactivity in the service of recovery (Lipowski, 1970). Capitulating, a behavioral coping style, is operationalized by the following items on the Coping Index. The parentheses () refers to the husband's responses on the Coping Index.

> I will die soon of cancer (my wife will die soon).
>
> I hate to attend social gatherings because of my illness (my wife's illness).

> I will never get well (my wife will never get well).
>
> I will never be able to enjoy life again (my wife will never be able to enjoy life again).
>
> I might as well give up because I can't make things better for myself (for my wife).
>
> My future seems dark to me (my wife's future).

Terminally Ill

Terminally ill refers to the wife who has an incurable cancer, and who is facing impending death. This status was determined by reviewing patient records by the researcher. Evidence of widespread disease via review of laboratory and x-ray reports confirmed the status terminally ill.

Family

Family is defined as a social system that is composed of a group of persons who have established relationships characterized by interdependency. Family members are linked together by emotional bonds and share an identity and a continuity (Duvall, 1977). A family includes those persons whom the individual identifies as having significant, and enduring impact on his or her personal welfare, but in this study is determined by blood or marriage. In this study, the focus will be on only the husband and wife in the family.

Limitations of the Study

The limitations of the study are as follows:

1. The sample size is small, and derived from the same oncology clinic. Therefore, the findings from this study may not be generally applicable to a large population, but only to the population under study.

2. Clients who agreed to cooperate in the study may be different from those who did not. It is possible that they would have had different outcomes.

3. The researcher who made the initial contact also assisted the participants to complete the Coping Index. Replication of the research, using at least two researchers, should eliminate any biasing effects.

Assumptions

Assumptions of the study are as follows:

1. A terminal illness is a life crises.
2. The relationship between the coping style of the husband and that of the wife is one that can be measured.
3. The testing instrument is sensitive enough to pick up differences between husband and wife.
4. Clients who seek medical care from a specialty group of oncologists via the referral system are the same as those found in other health care settings.
5. The period measured is representative of how the husband and wife truly feel during the terminal phase.

6. That the responses on the Coping Index reflect actual behavior and cognition of the individuals.

This study is organized into six chapters. In Chapter I an introduction, a statement of the problem, the hypothesis, definition of terms, limitations of the study, and assumptions are discussed.

In Chapter II a conceptual framework for this study is presented, focusing on related theory from psychiatry, crisis theory, and nursing.

In Chapter III a review of the literature pertinent to this investigation and supporting the need for this research is provided.

The methodology, design, and procedures used in this study, a discussion of the research sample, delineation of the procedures for data collection, and an explanation of the method and rationale for data analysis is provided in Chapter IV.

In Chapter V descriptive data and data analysis are presented.

A summary interpreting the findings and conclusions drawn from the study, as well as nursing implications and recommendations for further research concludes the study in Chapter VI.

CHAPTER II

CONCEPTUAL FRAMEWORK

Introduction

The conceptual framework presented in this chapter evolves from concepts in crisis theory and nursing. The conceptual framework is based on the assumption that a serious physical illness, such as cancer, is a life crisis.

Conceptual Framework

Through cognitive appraisal of the illness, the individual encounters a set of adaptive tasks to which various coping styles are applied. The group of seven tasks identified by Moos (1977) are generally characteristic of every illness. However, the importance of each task varies depending on the nature of the illness, personality factors, as well as environmental circumstances.

These tasks may be as difficult for family members and friends as for the ill individuals themselves. A family member such as a husband needs to recognize and understand the importance of these tasks in relationship to coping effectively. The tasks to be discussed below are common to all individuals and their families. The first three tasks presented are illness-related, the other four tasks are more general, and apply to all types of life crises (See Figure 1).

Illness-Related

1. Dealing with pain and incapacitation.
2. Dealing with the environmental factors and special treatment procedures.
3. Developing adequate realtionships with professional staff.

General

4. Preserving a reasonable emotional balance.
5. Preserving a satisfactory self-image.
6. Preserving relationships with family and friends.
7. Preparing for an uncertain future.

Figure 1.--Major Sets of Adaptive Tasks Necessary for the Development of Effective Coping

The first task deals with the discomfort, pain and other symptoms of the illness itself. The ill individual may anticipate distressing symptoms at certain periods, or actually encounter them at others. The family members are so closely involved with the ill person that they may experience pain for the cancer victim in the form of frustration and helplessness (Hamburg, 1975). This task may be a most difficult one, especially for the husband since his role is a dual one--helping his wife to bear pain, and accepting the task as one of his own.

A second task, related to the first somewhat, entails the management of stresses of special equipment and treatment procedures (Moos, 1977). Due to the advancement of medical technology, a host of new stressors confront the terminally ill individual. Not only must the patient accept the treatments and procedures, but the environment in which it is handled, as well as the side effects. A typical example of this is chemotherapy treatment, where the ill individual visits a clinic monthly to receive intravenous infusions in an environment so unlike home, without all the comforts. The side effects are often physically and emotionally taxing to both the cancer patient and the spouse.

Developing and maintaining adequate relationships with medical and nursing care providers constitutes the third major illness-related adaptive task (Backus, 1974). This task may become unusually complicated due to the frequent contact with the ill individual and the family. Caplan (1964) emphasizes the need for all those involved with an ill individual to support one another. By establishing a rapport with professional staff, the family expands its emotional boundaries in order to receive the necessary reassurance and guidance.

The fourth task, which presents itself in most major illnesses, is that of maintaining an emotional balance. When the patient is faced by an uncertain future, as with the diagnosis of a terminal illness, the associated anxiety and apprehension may be overwhelming. This places on the husband the task of helping his ill spouse to maintain some hope.

Preserving a satisfactory self-image and maintaining a sense of competence and mastery is the fifth task (Moos, 1977). The female cancer victim may encounter many types of treatments which may cause loss of function of a body part, disfigurement of a body part, or both. An identity crisis may occur for the woman due to her revised self-image. Life style and personal values may be altered, and may conflict with her husband's lifestyle and value. Both husband and wife together need to redefine together goals and limits of independence in light of the changes brought about by the illness. The need to depend on others for care--both physical and emotional, can be very stressful. Both husband and wife will encounter the difficult task of finding a balance between accepting help and actively participating in daily activities. The relationships formed with professionals in the third adaptive task will assist them through this period more readily.

The sixth task refers to preserving of relationships with family and friends. A serious illness can make it extremely difficult to keep communication lines open between husband and wife. If this occurs, both husband and wife alienate themselves from society. Successful problem-solving in the fifth task should guide them through this task of maintaining closeness with friends and family members. Without this relationship, comfort and support of those (family, friends) involved with the cancer patient cannot be afforded.

The seventh adaptive task involves preparing for the future. This imposes uncertainty, ambiguity, and threatens with significant losses (Lazarus, 1974). Patients must prepare for a loss of function, a body part, key roles in their life, and finally a loss of life. The family's role in this task, and more specifically the husband's is that of maintaining family integrity, and to prepare for the future together. When death seems likely, the ill wife and her husband must engage in anticipatory mourning, which begins the grieving process. At the same time a degree of hope is maintained that circumstances may change, and the wife and mother may improve in health status.

These seven major adaptive tasks as outlined by Moos (1977) and others are experienced by all persons with a serious physical illness, and their families. Through cognitive appraisal of the illness, the individual employs a variety of coping styles to deal with the adaptive tasks discussed above. These coping styles may be used individually, consecutively, or more likely, in various combinations. Certain coping styles appropriate in one situation may not be in another.

Shapiro (1965) refers to the term coping style as "a relatively enduring mode of functioning which can be identified in a person through a range of his specific attitudes and acts." When discussing coping styles in this study, it is assumed that individuals tend to display characteristic ways of perceiving, thinking, problem-solving, and acting when they develop a serious illness or when a spouse is involved with his wife's illness. One may postulate that coping with physical illness will reflect the individual's habitual modes of dealing with threatening and novel situations in general. However, it is difficult to relate coping styles from laboratory experiments to clinical observations (Oltman and Witkin, 1967). For the purposes of this study, several categories of cognitive and behavioral coping styles will be described. These coping styles, derived from clinical experience (Lipowski, 1970), will broaden the conceptual framework thus far presented.

Cognitive coping style characterizes the individual's intellectual functioning and is discernable in perceptual activities (Witkin and Oltman, 1967). The individual employs characteristic modes of thinking, and problem-solving in response to illness. Lipowski (1970) describes two different ways of cognitive functioning related to bodily disease. They are minimization and vigilant focusing.

> Minimization is the style characterized by a tendency to ignore, deny or rationalize personal significance of information input related to one's illness and its consequences.
> (Lipowski, 1970, p. 95)

The extent to which minimization is used varies among individuals, and at different stages of the illness within the same person. Clinical studies indicate that denial of illness, or at least minimization of its seriousness is common in the early phases of cancer victims (Feder, 1966). It appears, however, that some individuals employ minimization of a threat as a habitual mode of coping, and not just a transient response in the initial stages of illness (Hamburg, 1975).

Minimization implies a continuum of cognitive coping, ranging from total denial to reasonable doubt. An individual using minimization may be suppressing anger, projecting it onto someone else rather than oneself, or displacing the anger to a less threatening target, such as a spouse (Moos, 1977). The individual's use of minimization may enable isolation of dissociation of one's emotions when dealing with an aspect of the physical illness. In this way, minimization is actually rescuing the individual from being overwhelmed. This period is used for gathering other coping resources.

Vigilant focusing is the other cognitive coping style to be presented. According to Lipowski (1970), this style connotes:

> . . . a brisk response to perceived signals of danger and persistent attempts to reduce uncertainty and ambiguity about all aspects of illness.
> (Lipowski, 1970, p. 96)

When utilizing vigilant focusing, the individual initiates intellectual activities directed toward reestablishing equilibrium (Falek and Britton, 1973). Persons employing vigilant focusing seek new information which will help them to understand the illness or circumstances related to the illness. Adequate information can often relieve anxiety caused by uncertainty or misconceptions. Individuals who are feeling helpless may find that information-seeking gives them something to do and restores a sense of having some control (Hamburg, 1975). Those who use vigilant focusing regularly must know what is happening to them, and what the implications of their illness are, consistently trying to make sense out of the experience.

A husband may seek out further information about his wife's terminal illness for several reasons. He may attempt to determine the degree of responsibility for his wife's illness (initially blaming himself). He may scrutinize newspapers and magazine articles to find out information regarding treatment and procedures. Lastly, the husband may search for ways of coming to terms with his expected loss. Thus, it can be seen that not only the terminally ill wife employs this coping style to deal with her fate, but her husband as well. The degree to which they cope similarly is yet to be presented.

Behavioral coping styles can be described as "habitual modes of acting in response to illness shown by different individuals" (Lipowski, 1970). The emphasis is on predominant action tendencies of the individual, rather than on intellectual processes. The two behavioral coping styles to be presented are tackling and capitulating.

Tackling implies a disposition to adopt an active attitude towards challenges and tasks posed by the illness. Tackling is characterized by a range of behavior. At one extreme the individual encounters a tendency to fight the illness at any cost. The behavior manifested may appear to be irrational, such as using the diseased part of the body as if it were intact (Garrett and Levine, 1962). At the other end of the spectrum the individual's behavior is rational and directed toward the current demands of the illness. The tackling actions are aimed at prompt recovery, or at least compensation for a disability.

Capitulating is the other behavioral coping style to be discussed. Capitulating is characterized by passivity. Either withdrawal from or a dependent clinging to others commonly occurs. Persons employing this coping style demonstrate very little initiative or action to fight their illness. A degree of passive giving in or withdrawal can be the most adaptive form of behavior, especially during the acute stages of a serious illness (Lipowski, 1970). However, when the individual continually uses capitulating to deal with the illness, the coping style is no longer effective, nor recommended.

It is essential to acknowledge that coping styles are seldom used singly or exclusively. A husband may deny or minimize his wife's terminal illness while seeking further information from friends or the family physician. When the individual appraises the illness as a crisis, a variety of coping styles are needed to deal with the tasks involved. The four coping styles:

minimization, tackling, vigilant focusing, and capitulating will provde a useful manner in the development of the conceptual framework of this study.

Why does one individual respond differently from another to a life crisis like a serious illness? It must be recognized that an individual's reaction to a serious physical illness either to himself or someone else is dependent upon a variety of factors. Falek and Britton (1973) describe some of these variables: age, sex, initial psychological stability, education, and social and economic level. Prior experience in coping with stressful events and availability of resources for dealing with the illness are considered by Hill (1964). Thus, diversity is found in the literature describing responses to a life crisis due to innumerable intrapersonal, biological, and environmental variables.

Three general determinants of coping style are predominant in the literature. Insel (1974), Moos (1976), and Lipowski (1970) each discuss the characteristics that influence an individual's overall appraisal of an illness and the choice of coping styles. The relevant determinants fall into the following categories: intrapersonal factors, illness-related factors, and environmental factors.

Intrapersonal factors include those characteristics such as age, personality, intelligence, beliefs, and values. Both cognitive capacity and emotional state at the onset of the illness and throughout its duration are also included under intrapersonal factors (Lipowski, 1970). General ego strength and self-esteem also have a significant impact on coping with physical illness. An individual who feels insecure may rely more heavily on the minimization coping style than someone with a more positive self-image (Moos, 1977). The timing of the illness in the individual's life cycle also determines the person's ability and mode of coping. Langford (1961) presents a case for age and the stage of physical development as an important determinant to how one copes with a crisis. Physical illness during adolescence, for example, imposes an additional stress at this developmental stage. At the other extreme of age,

> the high frequency of brain damage in people over 65 years of age leads to the common occurrence of cognitive disorganization in response to physical illness and this impairs coping capacity.
> (Epstein and Simon, 1967, p. 145)

However, greater maturity and more extensive coping experience may provide the elderly with greater personal resources on which to draw.

Illness-related factors include the type and location of symptoms, and other aspects of the pathological process. The degree of functional impairment also contributes to the individual's coping ability. General progression of the illness, including the occurrence of complications, may also affect the coping style and its effectiveness. The more dysfunctional the body part, or the more dependent the individual on someone else, the greater taxing of coping resources (Lipowski, 1973).

The third major determinant of coping is that of environmental factors. Rahe (1969) contends that both the social and the physical environments of the ill individual and the family influence the mode of coping with physical illness. Features of either the social or physical environment can contribute to the stress of the illness, or serve as sources of help and support.

> The aesthetic quality of one's surroundings, the amount of personal space available and the usual degree of sensory stimulation may influence the patient's (and his or her relatives') cognitive functioning, mood, and general morale.
> (Moos, 1976, p. 17)

The social environment includes the relationships of patients and their families, and other social support, in the community (Lindemann, 1944). Friends, clergy, social service personnel generally comprise the social environment of the ill person and the family. Socio-cultural norms and expectations may also come into light here. How one reacts in times of crises may be dependent on societal norms and mores.

Intrapersonal factors, illness-related factors, and environmental factors all contribute to the subjective meaning that the illness has for the individual. This discussion emphasizes the complex nature of a person's psychological response to physical illness. More importantly, the ability of family members to help the individual and each other strongly impacts the choice of coping styles and the ultimate outcome.

Overview of Nursing Intervention

Crisis theory maintains that individuals experiencing a life crisis are more receptive to external support than they are during periods of more stable functioning. Nursing intervention can play a vital role in facilitating effective coping of the family unit, and of the husband and wife. In order to offer guidance and support, however, the nurse must be competent in many areas.

An understanding of the time dimension involved is a dual concern of nursing. Not only must the nurse recognize the developmental stage of the individual who is terminally ill, but also the developmental stage of the family unit. Ages of those involved (either patient or family member), years of marriage, number of children in the home, and significant roles identified by the family are all factors which may contribute to the coping ability of the individuals.

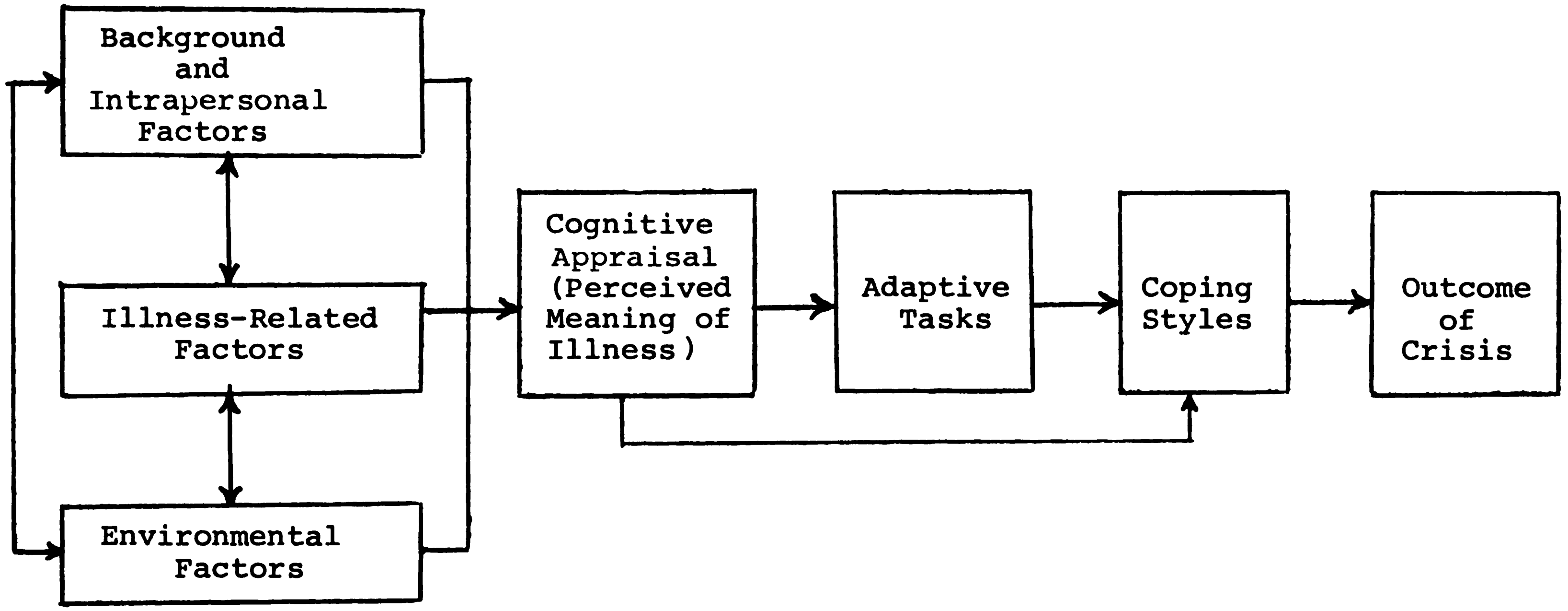

Figure 2.--Operational Model for Understanding the Crisis of Physical Illness (Adapted from Rudolf H. Moos, *Coping with Physical Illness*, New York: Plenum Medical Book Co., 1977).

Grieving for a loss (potential or actual) also entails an element of time. Again, the nurse must become adept at recognizing the progression of the grief process in order to lend support during this phase. The ill wife and her husband traverse through initial disbelief to a growing awareness of pain, sorrow, and often anger. Gradually the husband and wife begin to reorganize their lives, the loss is accepted and equilibrium is restored. It is essential that the nurse recognize each stage as it is, and not mistake denial for stoicism or label anger or depression as pathological.

By the nurse's awareness of the major adaptive tasks that the patient and spouse encounter, the nurse can be most helpful. Offering information is one of the most beneficial means of support (Moos, 1977). Responding to questions, anticipatory guiding by advising on events or emotions which are likely to occur, and identifying resources such as self-help groups or other community agencies will reassure the family that someone cares.

Two adaptive tasks presented previously warrant mention and elaboration here in terms of nursing intervention: preserving an emotional balance, and preserving a satisfactory self-image. Patients often deal with their general physical dependence by asserting their independence in other areas. This assertiveness may take the form of criticism, negativism, or not following the doctor's orders. Family members may also rely on asserting their independence in order to cope with the sense of helplessness, such as the husband helping with his wife's routine care. It is essential that the nurse recognize these actions as valuable means of coping with the assault on self-image. In the same way, the patient or family member is attempting to maintain an emotional balance. By offering opportunities for and encouraging independent action, the nursing personnel can contribute to the maintenance or restoration of a healthy self-esteem (Gruen, 1975).

Among the many recognizable features of the reactions of a family confronted with a terminally ill wife and mother is the similarity of their reactions to those of the ill individual.

> When a patient faces death, his family's reactions will, in essence, mirror his during each stage of the downhill progression.
>
> (Heimlich, 1970, p. 271)

To the extent that the nurse familiarizes herself with the patient's and family's reactions to the terminal illness is the extent to which management of the family and patient can be truly carried out in a wholistic manner. At the same time, those persons who are not coping effectively can be identified by the nurse, and appropriately managed through counseling or group therapy (Gruen, 1975). Understanding different coping styles between husband and wife can assist nurses with problems which arise when discrepant and incompatible coping styles are being used. An example of this is seen when a cancer patient is seeking information and emotional support, and her spouse is denying that there is anything wrong.

Nursing personnel also need to assess the background factors which facilitate or hinder various coping styles. Attention should be directed to adequate appraisal of the ill individual's social and physical environment, as well as personality factors. Focus on family and friends may enable the nurse to assist those involved with the patient to be more effective in helping the ill individual to cope. The impact that family, clergy, and other support systems have on the patient is important. By utilizing these resources in daily care of the terminally ill, the nurse will better manage both the patient and the family.

The goal of nursing when working with an individual or a family is to seek the highest level of functioning and to assist them in maintaining this stability. How the nurse accomplishes this depends on acceptance by the family, motivation of its members to make changes, and the identification of the problem (disorganization or ineffective coping). A model presented here is an appropriate mode of delineating some of the problems of families.

Giacquinta's Model (1977) focuses on ten phases of family functioning within four stages of cancer: living with cancer, the living-dying interval, bereavement, and reestablishment (see Figure 3). This particular model describes "hurdles" for the family to overcome. What is particularly unique is the incorporation of nursing intervention into the model during each family phase. Giacquinta's (1977) framework is the final section in the development of the conceptual model for this study. Be expanding on the model presented by Moos (1977) and the incorporation of Giacquinta's Model, a wholistic approach to helping the married couple through the terminal illness of the wife has evolved.

When the initial diagnosis of a terminal illness of the wife is revealed, the family, particularly the husband, may become disorganized. At this time a high degree of non-productive behavior may be evident, such as anxiety and withdrawal. Kubler-Ross (1969) maintains that this is a time which allows family members to collect themselves, and mobilize other resources. According to Giacquinta (1977) the family is at the impact phase where the major hurdle is despair. The goal of nursing intervention in this phase is to foster hope. By assisting the family to accept hope and to make plans by decision-making as a way of living through the crises, the family will use the experience for maturational growth. Minimization is the major coping style utilized during this first phase (Feder, 1966). The nurse must recognize the importance of this type of coping, but know when it becomes a habitual mode, and thus no longer effective.

Functional disruption is the second phase in the Living with Cancer stage. The shock that the members experience may lead to weakening in their commitment to mutual role obligation. The family unit may become further disorganized as members are pulled in various directions. The ill wife is no longer able to carry out all of her daily household tasks, for example, and this places an increased stress on the husband who may have to expand his role to include some of these duties. The instability that may occur between husband and wife roles may render them less able to reach out to other support systems (Scott, 1977). The hurdle, therefore, is isolation. The nurse can help the family to define priorities and additional resources needed. Capitulating is seen most commonly as the major coping style utilized during this phase. Communication, family member interaction, and social and emotional involvement need to be fostered by the nurse in order to combat ineffective coping leading to isolation. Relationships within and outside the family need to be sustained in order to support cohesion.

The third phase in the Living with Cancer stage is the search for meaning. During this phase there is a need to seek out information relevant to the ill individual's situation. The major coping style in use at this time is vigilant focusing. Both the ill individual and her spouse may be gathering new knowledge not only to understand the illness better, but also to ensure that it will not happen to another family member. Giacquinta (1977) refers to this hurdle as one of vulnerability, as the family recognizes the meaning of cancer. The nurse can attempt to foster security of the family members by allowing them to utilize both tackling and vigilant focusing initially. These coping styles will enhance the family's integrity and identity under this stressful event (Hamburg, 1975).

Informing others is the fourth phase that Giacquinta (1977) refers to in the Living with Cancer phase. The hurdle to be overcome in this phase is retreat. By strengthening the lines of communication within the family, and yielding direction and guidance toward priorities of action, the nurse can help the husband and wife to be courageous. The nurse may focus on the family to recognize its internal strength. By actively informing others outside the family about the terminal illness of the wife, the members will more likely ignore passivity, or capitulating as they realize the necessary relationships with friends, clergy, and other community resources.

The fifth and final family phase in the Living with Cancer stage is engaging emotions. Capitulating is the predominant coping style during this period due to the family hurdle of helplessness. Helplessness evolves from the belief that everything can be done for the terminally ill person has been done (Shea, et. al., 1970). This phase may be characterized by either a withdrawal from or a dependent clinging to others. The nurse can intervene when the mode of coping is no longer appropriate, such as with capitulating. Energies expended by family members in attempts to cope with the terminally ill wife and mother may be haphazard and ineffective. Nursing personnel may assist them in problem-solving measures on a daily basis. It has been noted by Giacquinta (1977) and others that families tend not to cope as well with a time limit on their loved-ones life. Energies are generally spent in post-poning death, and thus denying the valuable life the family still has together.

Restructuring in the Living-Dying Interval is the second family stage in Giacquinta's Model (1977). During this stage the indivdiual with cancer ceases to perform familiar roles and is cared for either at home or in the hospital. The first phase in this stage is that of reorganization. Role obligations must be redistributed among family members to lessen the strain on the family, especially between the martial dyad. Cooperation is fostered by the nurse so that family goals are effectively met. The husband and wife must be reminded that they are experiencing similar feelings and that they will never be alone if they continue to work together. Because household management and caring for young children may present problems, the nurse can assist all family members in visualizing their contribution toward meeting this problem. Again, the tackling style should be fostered during this phase.

Framing memories is the second and final phase in the Restructuring in the Living-Dying Interval. Just as the family needs time to form a clear picture of the impending death of their wife and mother, they need time for remembering the indivdiual's life history (Giacquinta, 1977). The threat of anonymity is the hurdle for the family to overcome at this phase. Family members may tend to block out recollection of their loved-one, and to focus on the seriously ill and dying person. By strengthening the image of their loved-one, the family can relinquish their dependence on the ill person's physical presence, and remember her without pain. The nurse can help them to do this by using scrapbooks, family photos, and encouraging the family to tell stories about the past.

Bereavement is the third family stage as presented by Giacquinta (1977). Separation and mourning are the two phases within this stage. Separation occurs when the terminally ill individual dies. The family fully realizes the loss and loneliness of separation. Self-absorption is the hurdle for the family to overcome. Capitulating is the coping style that the grieving family members are most prone to using. However, nursing intervention must be directed toward promoting intimacy. By supporting intimacy and cohesion the family is better able to grieve within their family network.

Mourning is the other phase in the Bereavement stage. This phase may last for an extended period. It is difficult for the nurse to follow the family through this period, unless she is a Nurse Clinician or a visiting nurse where she can maintain contact with the family. The obstacle to overcome in the mourning process, as described by Kutscher (1970) is guilt. Often the husband in the family may express relief that his wife is dead. This may resurface previous losses, and may hinder relief for some time. The mourning process is relieved only when the deceased person becomes internalized and enriches the continued family life (Giacquinta, 1977).

The final family stage is Reestablishment. This occurs after the completion of mourning, and encompasses the final family phase, that of expanding the social network. Alienation is the final family hurdle to overcome. The goal of nursing intervention is to foster relatedness so that self and family estrangement may be relinquished. Expansion of social networks increases the family's awareness for the need of other people and resources. Those who work through the grief associated with a death eventually take on new dimensions of growth and self-actualization.

In summary, those in the nursing profession have a unique responsibility to assist individuals whose lives have been disrupted by illness. With a general understanding of the major adaptive tasks and coping styles involved, as well as assessing pertinent intrapersonal, environmental, and illness-related factors, the nurse will be able to minimize the negative impact of the illness experience and support effective coping.

By intervening in the family functioning, the nurse can offer guidance and support to the members of the family at an interpersonal level. Giacquinta's Model (1977) has demonstrated how this can be done.

Points of transition in Individuals with Cancer	Family Stage	Family Phase	Family Hurdle	Goals of Nursing Intervention
Individual receives initial diagnosis of cancer; continuees to carry out role obligations with the family, and functions in varying ways as a family member.	Living with Cancer	impact	despair	fostering hope
		functional disruption	isolation	fostering cohesion
		search for meaning	vulnerability	fostering secuirty
		informing others	retreat	fostering courage
		engaging emotions	helplessness	fostering problem-solving
Individual with cancer ceases to perform familiar roles and is cared for either at home or in the hospital.	Restructuring in the Living-Dying Interval	reorganization	competition	fostering cooperation
		framing memories	anonymity	fostering identity
Individual with cancer dies.	Bereavement	separation	self absorption	fostering intimacy
		mourning	guilt	fostering relief
	Reestablishment	expansion of social network	alienation	fostering relatedness

Figure 3.--Operational Model for Helping Families Face the Crisis of Cancer (Adapted from Barbara Giacquinta, American Journal of Nursing, October 1977).

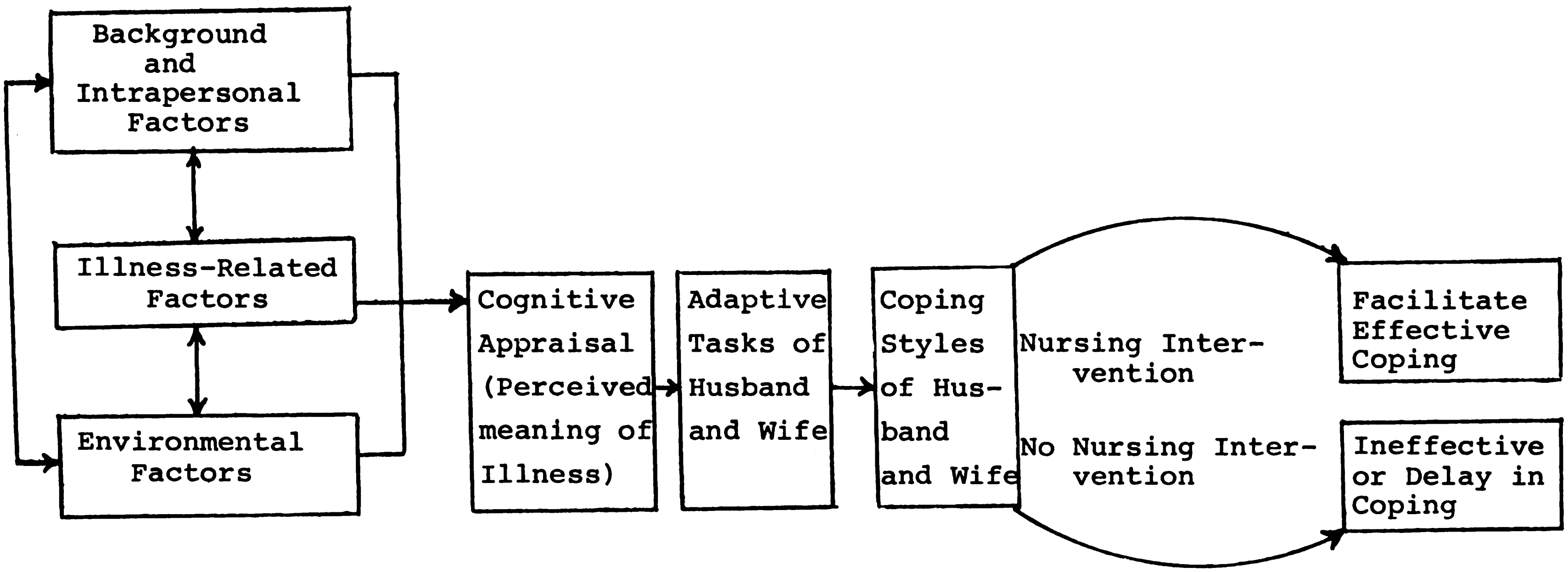

Figure 4.--Operational Model of Giacquinta's Model Applied to the Crisis of Physical Illness as Described by Moos.

CHAPTER III

REVIEW OF THE LITERATURE

Introduction

The review of the literature focuses on issues pertinent to the coping processes of individuals. Areas discussed are general concepts of coping, the coping processes of the individual affected by cancer, and the role of the family when a family member has cancer. The above issues are generally considered by crisis theorists (Holmes and Rahe, 1969; Kaplan, 1968; Caplan, 1964) and experts in psychiatry of medicine (Lipowski, 1970; Lazarus, 1966; Moos, 1977). The purpose of the literature review is to describe the process of coping when an individual is seriously ill, the impact the illness has on family members, and the role that the family plays in helping the individual through this crisis. Since the process of coping is the broad topic discussed, the general concepts of coping are initially presented in this chapter.

General Concepts of Coping

The meaning of the term coping is ambiguous as it is presented in the literature. Mechanic (1962), approaching the subject from a sociological viewpoint, defines coping as

> . . . the instrumental behavior and problem-solving capacities of persons in meeting life demands and goals. It involves the application of skills, techniques, and knowledge that a person has acquired.
>
> (Mechanic, 1962, p. 60)

In this sense, physical illness gives rise to adaptive tasks and challenges which individuals must attempt to master by utilizing psychological resources.

Another interpretation of coping is that of "strategies for dealing with threat," as suggested by Lazarus (1966). In the lengthy presentations of the coping process, Lazarus (1966), emphasizes danger signals and defense mechanisms as the basis of coping. In view of this perspective, physical illness, such as cancer, can be conceived as a type of psychological stress involving the threat of loss.

Although the above definitions differ in thier emphasis, they are complimentary. A definition which incorporates the ideas of both Lazarus (1966) and Mechanic (1962) clarifies the term coping more specifically. Lipowski (1970) provides an all-encompassing perspective of coping in the following definition:

> Coping is . . . all cognitive and motor activities which a sick person employs to preserve

> his bodily integrity, to recover reversibily impaired function, and compensate to the limit for any irreversible impairment.
> (Lipowski, 1970, p. 93)

When viewed as a life crisis, physical illness imposes certain tasks that must be accomplished (Moos, 1977). The individual's capacity to meet the tasks is somewhat impaired during the crisis state. Coping, then, must include both aspects as presented by Lipowski (1970), that of dealing with an immediate danger, such as pain to preserve bodily integrity, and that of employing the adaptive tasks to regain total functioning.

An individual's ability to cope effectively with a serious physical illness depends on a variety of factors. The three general determinants of coping as described by Insel (1974), Moos (1977), and Lipowski (1970) were presented in Chapter II. Intrapersonal factors (i.e. age, personality), illness-related factors (i.e. type and location of symptoms), and environmental factors (i.e. social setting, culture, and support systems) all contribute to the meaning the illness has for the individual. In addition to these factors Hill (1964) suggests the specific event (i.e. physical illness), previous experiences with the event, and the meaning that the individual assigns to the event as essential aspects to consider in evaluating an individuals' ability to cope effectively. An event which is so novel or so major that the individual's usual way of coping is inadequate significantly influences the ability and effectiveness of coping (Caplan, 1964).

Coping styles develop out of an individual's perception of his illness (Rahe, 1969). The term coping style was coined by Shapiro (1965) in reference to an enduring mode of functioning. The coping styles identified from the works of Janis (1958), Shapiro (1965), Lazarus (1969) and Lipowski (1970) were presented in Chapters I and II. Vigilant focusing and minimization are the two cognitive coping styles commonly presented in the literature. Cognitive coping styles are characterized by intellectual processes, such as problem-solving. Falek and Britton (1973) refer to the individual who actively seeks new information regarding illness or other stressful situations as one who employs the coping style of vigilant focusing. Minimization is the style characterized by a tendency to ignore, deny, or rationalize information obtained about the physical illness (Lipowski, 1970). Two behavioral coping styles are also prominent in the literature, although usually under different names: tackling and capitulating. The emphasis is on action tendencies of the individual rather than on intellectual processes. Tackling implies the adoption of an active attitude towards tasks posed by the illness. The actions are aimed at prompt recovery, or compensation for a disability. Capitulating is seen as the opposite of tackling. This style of coping is characterized by passivity. Individuals employing capitulating show very little initiative to combat the illness.

How an individual copes with a serious physical illness is a resultant of both the multifactorial determinants _and_ the coping styles. Numerous intrapersonal as well as interpersonal factors are involved at any given episode of the illness. Thus, the _strategies_ one uses are more varied and changeable than the coping styles. Coping strategies can be defined as the "techniques actually used by the sick person to deal with the illness and its consequences" (Lipowski, 1970). The coping style and the varied attempts of the individual to combat the illness are reflected in the coping strategies. A broad range of coping strategies have been described in the literature, particularly in relation to chronic illnesses, such as cancer (Garrett and Levine, 1962; Janis, 1958; Chodoff, 1964).

The assumption that coping strategies are evolved from the individual's personal meaning of the illness, as are coping styles is well substantiated in the literature (Hamburg, 1967; Stavraky, 1968; Moos, 1977). Both clinical observations and current literature distinguishes common categories of the meaning of illness to affected individuals (Lipowski, 1970). However, there is a surprisingly lesser degree of research regarding the meaning of illness to significant others of the affected individual. Such meanings of illness reflect past personal experiences, cultural expectations, and individual beliefs and values. The meaning of the illness to an individual influences emotional and motivational responses to illness, and thus the coping strategies (Hill, 1964). The following constitutes a list of the four most prevalent meanings of illness with associated coping strategies compiled from the current literature.

1. Illness as enemy: The individual is called upon to fight or flee from the situation. Coping strategies include denial and projection. Passivity and a sense of helplessness may be expressed as a sign of surrender. A fighting attitude used as a coping strategy may also be prevalent when illness takes on the meaning of enemy. Stavraky, et al. (1968) reported that in a group of thirty women suffering from terminal cancer, those who dealt best with their illness had "strong hostile drives."

2. Illness as weakness: The individual views the illness as a sign of failure. Generally, this

meaning of illness takes on a degree of shame or guilt. Coping strategies commonly employed are denial or being a model patient (Lipowski, 1970). Abrams and Finesinger (1951) reported the marked tendency to explain the development of the disease (cancer). In this study 50% of the sixty patients studied blamed their own past actions as the cause of the cancer. The remaining half attributed it to someone else. In yet another study, Moses and Cividali (1966) found that 20 of the 30 subjects who had cancer blamed others, whether it be heredity, rejection, or poor medical care, while 8 blamed themselves.

3. Illness as challenge: This is a common meaning of illness for individuals. The disease is viewed as another life situation which imposes tasks to be mastered. Chodoff (1964) refers to this meaning of illness as an "insightful acceptance." The coping strategies associated with illness as challenge are seeking medical advice, cooperation, and information-seeking as described by Hamburg and Adams (1967). In their study of life-threatening illnesses (severe burns, poliomyelitis, and childhood leukemia) meaning of illness for those physically affected, as well as those who were not, became another life event that challenged everyday resources of coping.

4. Illness as relief: The individual welcomes a relief from demands and responsibilities. The danger with relief as the meaning of illness is that the individual may cling to the sick role beyond physiological recovery (Lipowski, 1970). Hypochondrial complaints and overuse of health care facilities are common coping strategies employed at prolonging disability.

In summary, the nature of coping is influenced by many aspects in an individual's life. The effectiveness of coping, and its outcome is dependent on intrapersonal factors, environmental factors, and illness-related aspects. The individual's perception and cognitive appraisal of the meaning of the illness is also a determinant of coping. This overview of coping was presented to provide the groundwork for the ensuing sections in the review of the literature. The following section relates to stressors impinging on the individual with cancer, and the mechanisms of coping in effect.

Coping with Cancer: The Affected Individual

To appreciate the variegated patterns of individual adjustment to the stress of cancer demands an understanding of many things at once. Factors such as personality, relatives, passage of time, attitudes interact with each other in an ever-changing equilibrium (Hinton, 1973). In this section attention will be given first to the reactions in the early stages of recognizing cancer; secondly, to the stressors borne by those with cancer, and lastly, to the ways individuals cope with the disease.

The disruptive effect that the diagnosis has on an individual is well substantiated (Shands, 1951; Aylett, 1965; Hinton, 1973). Generally, the initial response of one who has been told he/she has cancer is of shock and disbelief (Shands, 1951; Kubler-Ross, 1969). The individual may appear to be stunned for some time. Such a reaction follows the sudden recognition of having cancer.

The clinical onset of a neoplastic disease does not necessarily announce the diagnosis. Minor non-specific changes in health status may cause the individual with cancer to be justifiably ignorant (Hinton, 1973). Continued alterations in health, or the advice from family or friends to seek medical opinion may prompt the individual to begin recognition of the seriousness of the illness.

Rowe-Jones and Aylett (1965) reported that the delay in seeking professional advice for cancer is not due solely to ignorance. The average time before a patient sought advice for symptoms due to cancer of the colon in the research done by Aylett, et al. (1965) was seven to ten months. Several studies have also been carried out in women with breast cancer. Henderson (1966); Aitken-Swan and Peterson (1955) in studies of 100 women with breast tumors, found that 70% and 62%, respectively, delayed more than three months before consulting a physician. However, in more recent studies Cameron and Hinton (1968) discovered only 23% of the one hundred women interviewed waited more than three months to consult a physician. The emphasis on consumer awareness in the last decade, as well as the advent of self-care attitudes of health care providers may have influenced the more recent population under study.

In yet another study related to time delay in seeking medical advice in cancer patients, Goldsen (1963) took into account environmental and personality factors, as well as previous experience with cancer in the population interviewed. Demographic data were obtained from 30 cancer patients. Previous attitudes toward and experiences with cancer were also revealed by the subjects. The findings included the following: individuals with a lower level of education or occupation delayed more often in seeking medical advice; a delay in seeking a medical consult was also noted in those individuals who demonstrated an attitude of "fear of no cure" (Goldsen, 1963).

The results of the studies presented above demonstrate the degree of minimizing of symptoms by those who have cancer. The impact that the diagnosis has on individuals, and the varying factors which may influence the delay in seeking advice is also emphasized. More research is needed to discover the initial reactions of signficant others when they suspect a loved one has cancer. Discoveries in this area may also add to the present factors affecting the cancer victim's initial reactions toward the illness.

Cancer poses certain stressors on the affected individual. Holmes and Rahe (1967) refer to stressors as "any set of circumstances the advent of which signifies or requires change in the individual's ongoing life pattern." There are immediate as well as latent stressors associated with cancer. Pain and nausea, both latent stressors, may be particularly distressing to the patient (Hinton, 1973). For the patient the future may appear foreboding rather than hopeful. Discomfort, mutilation, or death may be anticipated and feared. Other changes in the individual such as altered physical appearance, a loss of social status, separation from family members, and all the implications of being a patient rather than a person may produce stress (Moos, 1977).

Hinton (1973) investigated twenty (20) individuals with cancer in order to determine the stressors most commonly affecting them in daily living. The stressors mentioned here appeared to play a significant part in causing distress since they were cited by at least 5% of the population.

1. Pain: In the majority of cases the pain was directly due to the neoplasm, in other cases pain was partly or largely a manifestation of psychological disturbance (Hinton, 1973). Pain that was a direct symptom of disease was capable of being modified by medications. This lessened the severity of the stressor on the individual.

2. Alteration in body image: Disfigurement was the greatest threat to bodily integrity. General wasting, mastectomy, and hair loss were areas considered by the women as hardest to bear (Hinton, 1973). Deep concern over the future was voiced frequently. Continued deterioration of bodily function and the possibility of dying were also sources of great stress.

3. Loss of work role: Individuals expressed concern that they would no longer be an active part of

the working society. The loss of close relationships and social status intensified the magnitude of this stressor.

4. Dependency: Fear of being a burden on others was another aspect of social and psychological disruption.

5. Alienation: Individuals expressed the need to be wanted, but sensed that many people no longer cared about them. Because of the loss of work roles, the stressor of alienation was even more magnified than some of the others.

This list of stressors underlines the diversity of concerns that impinge on those affected by cancer. Although the above list of stressors may not be complete, the mentioned five signify the multifaceted nature of the personal meaning that cancer has in the daily lives of those involved.

Cancer presents a real and sometimes most serious threat to the welfare and survival of an individual (Sensecu, 1963). Although each patient looks upon the illness in a unique manner, there are some broad generalizations which can be drawn from the literature. Basically, the patient perceives the illness as a threat to his bodily integrity (Abram, 1972). How the patient accepts the loss and the personal meaning attached to the loss becomes of prime importance in terms of coping. Secondarily, the illness affects the interpersonal aspects of everyday living, as well as relationships with friends and family members. The illness or its treatment may place restrictions on the individual, and may result in changes in life style. These changes and restrictions frequently affect the individual's overall coping style. Likewise, the patient's family and others closely involved both affect and are affected by the illness. The responses of family and friends to the illness may directly or indirectly influence the patient's coping style in a significant fashion (Abram, 1972).

Although cancer imposes certain stressors, every individual develops particular modes of coping with the stressors, and generally follows a preestablished pattern. Lipowski (1970) distinguishes an individual's coping style from the coping strategies actually employed by the ill person. This approach to the process of coping does, of course, include the use of psychological defense mechanisms (Shands, 1951; Senescu, 1963; Abram, 1972; Wasserman, 1976). The threat to bodily integrity and the potential changes in life style and interpersonal relationships give rise to conflicts and anxiety which each person handles through various defensive maneuvers (Abram, 1972).

Defense mechanisms are commonly discussed in the literature in relation to how individuals cope with physical illness. Lipowski (1970) has included an emphasis on cognitive coping styles whereby an individual may either minimize available information about the illness, or focus vigilantly upon perceived dangers in an attempt to reduce uncertainty. Associated with the cognitive elements are the active, passive, or avoiding styles. The coping styles described by Lipowski (1970) as tackling, capitulating, minimization, vigilant focusing, and avoiding overlap with the defense mechanisms and the strategies used in coping (Moos, 1977).

The three more commonly described defense mechanisms in the literature are regression, denial, and intellectualization (Abram, 1972; Rothenberg, 1961; Senescu, 1963). Prior to the description of research findings related to defense mechanisms and coping, definitions of the more frequently used defenses will be presented.

Regression is a defense mechanism which is characterized by adopting earlier modes of behavior which at one time were comforting and useful (Abram, 1972). Regression is considered to be noneffective coping in the chronically ill, and generally is used by the individual who attaches the meaning of illness as "relief," as described by Lipowski (1970). The need to be cared for and the opportunity to give up adult responsibilities often become alternatives to the cancer patient. There is a tendency for the individual to employ capitulating as the major coping style.

Denial is used by the ill individual to decrease the awareness of danger that cancer poses to bodily, psychologic, and social functioning (Broden, 1970). Denial may help one's efficiency in daily living by keeping out of awareness all the dangers that confront the ill person. However, if denial prevents the patient with cancer from seeking medical attention, this defense mechanism is no longer deemed effective. Minimization is the more commonly employed coping style associated with denial. There is a tendency for one to deny, ignore, or rationalize information related to the illness. Clinical studies (Feder, 1966) indicate that denial of illness or its significance is common in the early phases of cancer.

When an individual employs an overtly intellectual approach to the illness, the major defense mechanism in use tends to be that of intellectualization. Through seeking more information about cancer, the affected person attempts to remove the "emotional sting" associated with the disease, and at the same time to conquer feelings of anxiety. The patient who constantly reads about his/her illness to acquire more knowledge is really doing so in an attempt to maintain some control over the disease (Abram, 1972). Vigilant focusing is the coping style related to the defense mechanism of intellectualization. Individuals employing vigilant focusing find it necessary to reduce all uncertainty about the illness. By intellectualizing, the individual tries to make sense of the experience (Lipowski, 1970).

Thus, regression, denial, and intellectualization are strongly associated with modes of coping, or more specifically, the individual coping style. The presentation of these three defense mechanisms helps to broaden the total perspective of coping with a physical illness, such as cancer. The research findings that follow only reemphasize how complex the process of coping truly is.

In the study by Achté and Vouhkonen (1970), 100 cancer patients were interviewed in regard to the awareness of their illness. Sixty-eight people appeared to know and accept that they had cancer. Thirty-one people ignored or denied the diagnosis of cancer. The 31 who ignored or denied that they had cancer included 7 who had been told the diagnosis by the doctor, 2 of them at the patient's own request. This study is an example of how strongly the defense mechanism of denial, and the associated coping style of minimization affects one's ability to deal effectively with the illness. The major weakness in this study is the lack of information available regarding the time element between the date of diagnosis and the date of interview. Feder (1966) demonstrated that a strong denial is a commonality among newly diagnosed cancer victims, but is of lesser intensity as time elapses during the illness.

Moses and Vicidali (1966) investigated to see what factors could influence the awareness of 30 people with cancer. The 30 subjects were graded along a continuum of awareness. The findings presented no relationship between the level of awareness and age, sex, marital status, or ethnic origin. A significant association of greater awareness with higher education, however, was prominent. This study only focused on the minimization aspect of coping, as did that of Achté and Vouhkonen (1970). Future areas of research in coping need to include the other coping styles as stated in the literature: tackling, vigilant focusing, and capitulating.

A recent study by Hinton (1976) attested to discover coping styles other than minimization. In a group of sixty people with progressive malignant disease reaching the terminal phase, the coping style of tackling was demonstrated in 33% of the subjects. Those people employing this coping style attempted to maintain some hope in their lives, often by setting limited goals toward independence. These findings, though limited in scope, are valuable in terms of learning the circumstances under which one uses varying coping styles.

It is not solely the patient who has a burden to bear when cancer is diagnosed. Often it involves the affected individual's family members, especially a spouse. Hinton (1976) describes the married couple as bearing the situation together in many, if not all, respects. Ironically, however, research in the area of how the married couple copes with a terminal illness of a spouse, is minimal. Therefore, the next section presents a review of the literature related to family coping in general, with implications for further study in the area of the marital dyad.

The Role of the Family in Coping with Cancer

A serious and prolonged illness such as cancer is a common source of stress that poses major problems of adjustment, not only for the patient but also for family members. It is essential to emphasize the family as well as the individual reactions in coping with stress since it is the family who mediates the reactions of its members (Kaplan, 1973).

Individuals in a family do not generally resolve their own problems. Vincent (1967) states that "the family is uniquely organized to carry out its stress-mediating responsibilities." There is no other social institution that has demonstrated a comparable capacity for mediation that affects so many people in the community (Kaplan, 1973).

Since the family has a commitment to protect its members under a broad range of stressful situations, those in the nursing profession must extend their concern beyond the ill individual, at least to members of the immediate family. The nurse must offer help and support to the family members when needed to handle and resolve specific stressful situations related to the cancer patient.

> If the stress is great enough and sufficiently prolonged, the role of the family as a buffer for its members can be permanently impaired or even destroyed.
>
> (Kaplan, et al., 1973, p. 60)

In order to prevent the family from being impaired or destroyed as a buffer system for its members, more must be learned about effective individual and family coping.

To understand the process of coping with severe stress, such as with cancer would allow those in the nursing profession and others, to offer more guidance to improve or alter coping in family members. Both clinical and preventive value could be substantially gained by further study of the coping process. When a family copes effectively with the stressful conditions encountered with a member who has cancer, the ability of the family to continue as a viable unit is assured. Not only does effective coping offer protection (buffer) for the family members from high levels of stress, but also allows the family to meet the changing needs of its members.

Because the family is "the bottleneck through which all troubles pass" (Hill, 1968), no other social unit so reflects the stresses of life. Families have notably had a long history of stresses, and have worked out alternatives and plans for meeting problematic situations as they arise. The family, then, has developed a repetoire of resources for coping with stressful events. The following section describes the effect of serious illness on the family, and delineates the critical role of the family in resolving problems related to stress.

The Impact of Cancer on the Family

Crisis theory suggests that both individual and family reactions to a serious physical illness are fashioned from one to four weeks after the diagnosis is confirmed (Caplan, 1964). Both effective and ineffective coping becomes evident then. Early identification of coping is essential so that nursing intervention may help to reduce the incidence of families coping inadequately. Rapoport (1961) suggests that coping styles are not as fixed as they become later in the disease process. Crisis theory experts indicate that the ideal time to assess family coping ability is during the early phase following diagnosis.

Because of the severe stress precipitated by the diagnosis of cancer many other problems arise in addition to those involved in caring for the cancer patient. Hinton (1976) described five relevant stressors impinging on the individual: pain, alteration in body image, loss of the work role, dependency, and alienation. These were previously presented as sources of stress for the individual with cancer. However, if the individual is a part of a family, these same stressors impinge on the other family members as well. MacVicar (1976) indicates that stress is disruptive to the network of relationships which constitute the family system. When a stressor, such as the loss of a work role, occurs in a family, alteration of roles must be completed. Reorganization of family role assignments is essential to reach a new equilibrium. The ability of family members to modify their respective roles, perform tasks vital to the continuity of the family unit, and redefine personal expectations and goals demonstrates the ability of the family to cope effectively with the stressful situations (MacVicar, 1976).

For any serious illness, coping demands are not static, but change as the illness progresses. The ability of the family to continue to cope effectively with the progressive illness will depend on three factors: the meaning of the event (cancer), the resources available to the family, and the stressor itself, the family member's cancer (Hill, 1964). The key factor as presented by Hill (1964) is the meaning that the family ascribes to the event. Not all families respond to stress in the same manner to the same events. What would be a relatively mild crisis for some could be a disaster for others. This suggests that the stressful events are relative to the family.

Glasser and Glasser (1970) suggest that the stress meeting resources of a family are divided into two areas:

(1) Exogenous familial resources: money, insurance, friends, and community resources.

(2) Endogenous familial resources: personal skills, education, health, interpersonal behaviors.

(Glasser & Glasser, 1970, pp. 273-290)

The exogenous resources are helpful in minimizing the stressor events so that temporary solutions can be found. However, most sources of external support are extinguished sooner or later in the disease process. This indicates that the endogenous resources are critical in determining how the family manages to cope with the stress of cancer.

The literature refers to family characteristics that represent the endogenous resources in a family. Glasser and Glasser (1970) summarize these characteristics into three:

> (1) Family involvement: commitment to, and participation in, family life by members of the unit.
>
> (2) Family integration: interdependence of family roles.
>
> (3) Family adaptation: ability to change specific responses to varying situations.
> (Glasser & Glasser, 1970, pp. 273-290)

The concept of involvement suggests a commitment to family life, to participate in all activities of the family, and to appreciate what the family unit offers for the individual family member. Family integration indicates the existence and acceptance of individual roles in the family, as well as the need for an overlapping of roles among the members. This need not take away from each one's independence, rather it should strengthen the relationships that bind them as a family., The characteristic of adaptation demands flexibility of family members. If there was only one way of doing things, adaptation could not occur (Glasser, 1970).

When a family is characterized by involvement, integration, and adaptation, the environment in which the members live together continues to be a place of support, nurturance, and warmth. Without these three characteristics the family cannot continue to cope effectively with the stress that cancer imposes on them.

Research findings related to how families cope with cancer again are somewhat limited, as are those on the marital dyad. There is more abundant information on the family coping with a seriously ill child than with an adult (Chodoff, 1963; Hamburg and Adams, 1967; Falek and Britton, 1973). However, some of the concepts and findings related to the literature on children are of value in terms of understanding overall family reactions to a terminal illness of one of its members. Therefore, the following section is devoted to the presentation of research findings related to all types of family situations related to cancer.

Kaplan, et al. (1968) relates that observation of families who are experiencing the crisis of a leukemic child suggests that those who reach an understanding of the diagnosis of leukemia in the early phases of the disease are better able to cope through the entire process. This does not mean that those families who more readily accept the diagnosis do not encounter considerable anguish in doing so. The realization that the child is terminally ill in itself provides reason for family mourning (Kaplan, 1973). As the family recognizes the stressors involved in what could be a long term illness, and the adaptive tasks associated (Moos, 1977) with the illness, anticipation of the eventual loss of the family member ensues. Giacquinta (1977) also relates this concept of the family members readying themselves for the eventual loss of a family member, not necessarily a child.

Throughout the literature on family coping emphasis is placed on the importance of reciprocal relationships among family members (Bozeman, 1955; Vincent, 1967; Friedman, 1963). One function of the reciprocal relationships is to provide mutual assistance to members under stress. Members expect others in the family to help them meet their needs. When one member fails to respond to another's need for support, a decrease in the effectiveness of family coping is inevitable.

Kaplan's (1973) research in family coping bears out the need of family members to support one another. In a study by Kaplan (1973) sixteen couples who were experiencing a terminal illness of a child in the family were interviewed regarding the importance of communication between husband and wife. The responses gathered from the sixteen married couples did not vary to any significant degree. Kaplan (1973) discovered that a theme underlined the subjects' feelings regarding overall family communication:

> A family must have the closest possible cooperative relations to obtain the discipline it requires for living through the siege imposed by a child's serious illness. Such close relations are based on trust, honesty, and mutual support . . . impossible to maintain if the family fails to handle the initial coping tasks adequately.
> (Kaplan, et al., 1973, p. 68)

Friedman (1963) describes a study in which forty-six parents of children with neoplastic disease were interviewed. The interviews were primarily concerned with each parent's perception of the child's illness and clinical course, the defenses utilized by the parents to protect him/her from the impact of the stressful situation and the threatened loss, and the individual ways of dealing with the many problems that arise when caring for the seriously ill child (Friedman, 1963). Reciprocal relationships were also observed among the husbands and wives. Among those described were: the wives tended to keep their husbands informed about new treatments or diagnostic procedures proposed by the physician; the husbands tended to take on the major responsibilities for making decisions regarding the child's welfare, and also "tended to offer emotional support to their wives." The results obtained from the interviews revealed that parents who have a child with leukemia do share many similar problems that are inherent in the situation, and certain modes of adjustment commonly occur in a characteristic sequence. These findings are significant in the respect that parental behavior, though not stereotyped, is somewhat predictable.

Both the studies by Kaplan (1973) and Friedman (1963) clearly illustrate that coping is a family matter, and that the coping process is not effective when key family figures do not participate.

The inadequacy of research regarding the similarities and/or differences in coping styles between husband and wife is unfortunate. However, studies closely related to the subject are available and may lend informative data regarding coping of the husband and wife when the one spouse has a terminal illness. The following summarizes the work done in this area.

Gullo (1974) studied the responses of 16 women to the impending death of a husband. The women were interviewed in respect to three periods: reactions when they first learned of their husband's life-threatening illness; reactions when the husband's condition deteriorated to the point of being terminal; and reactions when the husband's death was imminent. The study focused on identifiable patterns of psychological, psychosomatic, and somatic reactions of the wife. The results of Gullo's study (1974) suggest that many of the initial reactions to the husband's life-threatening illness are similar to that of the ill husband himself. Depression, anxiety, feelings of inadequacy, changes in personal habits and role functions were demonstrated by the 16 women. As in the study by Hinton (1973) these are common emotional responses of the cancer patient as well.

In summary, individuals, marital dyads, and entire families have characteristic patterns of coping. Although the literature substantiating this fact is limited, broad generalizations can be made until further data is acquired. Cancer in its different manifestations and stages presents all those involved with a variety of challenges requiring a whole repertoire of coping styles. It is important for the individuals and families who are struggling with cancer, and for those attempting to help them, to understand the adaptive processes and the situational and psychological requirements which affect the coping process. It is imperative that future research studies focus on the marital dyad in the family more closely so that this relationship in coping with cancer can be better understood, and the coping processes of <u>both</u> the husband and wife effectively supported.

CHAPTER IV

METHODOLOGY AND PROCEDURES

Overview

The descriptive study was designed to identify similarities in the coping styles of the marital dyad, when the wife is terminally ill. The study specifically measures: (1) the differences between mean scores of the two cognitive styles (Vigilant Focusing and Minimization) of husband and wife; (2) the differences between mean scores of the two behavioral coping styles (Tackling and Capitulating) of husband and wife; (3) and the differences between the mean scores of Coping Style (Total) of husband and wife. To evaluate the difference between the two sample means the t-test for small sample means was used.

The t-test makes three assumptions about the data obtained. The first assumption is that scores form an interval or ratio scale of measurement. The second is that there is a normal distribution of the characteristics in the population. The third is that there is an equality of population variance with an equal μ in each group (Borg and Gall, 1971). The t-test is the appropriate analysis for this study because the total sample does not exceed thirty.

Using preestablished selection criteria, a population of women diagnosed as terminally ill was selected from an oncology clinic located in an urban community with a population of approximately 200,000. This clinic derives its caseload from a referral system only. From this population the data were compiled using an instrument based on a Likert Scale. The Basic Data Profile Sheet (see Appendix B) identified individual characteristics and demographic data of each study participant. This profile sheet was completed by husband and wife in their homes, and returned to the researcher via the mail. The Coping Index was the instrument designed to measure the coping styles of the husbands and wives, when the wife was terminally ill (see Appendix C). The Coping Index was completed in each couple's home with the researcher present. Results of the data were analzyed by t-test (assuming non-independence) to determine the differences between the two sample means.

A pilot study using five terminally ill women and their husbands was conducted to test the procedure and refine the instrument. Revisions were made concerning item sequence and wording in the Coping Index, no revisions were made in the Basic Data Profile Sheet. After these revisions were made the study was implemented.

The purpose of this chapter is to present the methodology and procedures involved. Included are the population, description of setting, the instrument, data collection procedures, instrument scoring, data analysis, and human rights protection.

Population

The population selected for the study were adults with cancer ranging in age from 40-65. The criteria for selection were based primarily on age, sex, seriousness of illness, and marital status. Only those married women who were diagnosed as terminally ill and in the age range of 40-65 were selected for the study. The rationale for selecting the age range of 40-65 was determined from research on individual and family developmental stages as described by Duvall (1977). Throughout the middle years the married couple alone constitute the nuclear family, maintaining their husband-wife interaction as the central interpersonal relationship. Because the middle years are bound by age and developmental tasks, and since a greater number of women who met the criteria were found to be between the ages of 40-65, this age range was selected. Therefore, age as a criterion for selection was deemed necessary in order to reduce one source of variation between the participating individuals.

Another criterion, that of being diagnosed as terminally ill was selected for several reasons. When an individual is diagnosed with cancer, it does not necessarily imply that death will ensue as a result of the disease. Therefore, those who are diagnosed as terminally ill, and realize the consequences of their illness, may cope with the circumstances and stressors of cancer differently from those who know they will not die due to cancer. The women who were identified as terminally ill met one or more of the following criteria: (1) were diagnosed as "terminally ill" by a physician, as written in the patient's medical record; (2) were diagnosed as having "widespread metastatic disease" by a physician, as written in the patient's medical record; (3) as evidended by laboratory and radiology reports indicating "widespread metastatic disease" found in the patient's medical record. By delimiting the population according to the seriousness of the cancer, another source of variation was reduced.

A third criterion in this study was that of being married and living in the same household with the husband. First, it was essential for the woman to have a husband so that both could complete the questionnaire in order to determine coping styles of husband and wife. Secondly, the requisite that the husband and wife live in the same household was necessary so as to minimize stressors other than the cancer itself (i.e. separation and divorce). Those who live together tend to share the burden that terminal illness imposes on their lives (Kaplan, et al., 1973). Another criterion, that of literacy with the English language, was vital to the completion of the questionnaire with full understanding of each item. The final criterion of willingness to participate in research evidenced by a signed consent form indicated to the researcher that the individual with cancer was emotionally prepared to be an active part of research. Standard criteria for selection of participants are presented in Figure 5.

Participants must meet the following criteria:

A. Sex--female.

B. Age--Range 40-65 years.

C. Diagnosed with a terminal illness.

D. Married and living in the same household with husband.

E. Literate with the English language.

F. Willingness to participate in research evidenced by a signed consent form found in the medical record.

Figure 5.--Criteria for Selection of Participants in the Study.

Description of Setting

Only one clinical site was used in the study for the purpose of obtaining a population. The clinical site chosen is a specialty clinic in oncology located within an ambulatory care center situated in an urban community. The population of this community is approximately 200,000. This particular oncology clinic serves over 2,000 people in the community and surrounding areas. The clinic derives its caseload from a referral system only.

Actual data collection did not take place in this oncology clinic. The rationale for not using the clinic for data collection procedures are the following: (1) the clinic provides for a very high volume of patients. In a four hour period 24-31 cancer patients are seen by health care providers. Because the patient's time spent with the physician is limited, and because available space did not permit it, the researcher did not distribute the instruments to the study participants in the clinic setting; (2) because the husband had to complete the Coping Index at the same time as his wife, this would have required the husband to attend the clinic with his wife. This was not feasible for many of the husbands who had work obligations; (3) the researcher assumed that the married couples would be more comfortable and relaxed in their own homes, and thus complete the Coping Index in a more serene atmosphere than that of the busy clinic.

During the home visit the researcher distributed the instrument to each husband and wife. Both husband and wife completed the instrument separately, although each had an opportunity to ask questions of the researcher pertaining to particular items on the Coping Index. The instrument took each couple approximately 10-15 minutes to complete. Following completion of the Coping Index the researcher stayed and debriefed with the couple. Generally the focus of the conversation was on the couple's personal concerns of the wife's illness. The researcher usually spent another 15-20 minutes with the couple during which time much reassurance and guidance were afforded.

The Instrument

The development of the instrument, pre-pilot testing, pilot testing, reliability and validity of the instrument are presented in this section.

The initial content for items in the Coping Index emerged from a literature review. The content for the instrument evolved from the four coping styles described by Lipowski (1970) and the list of coping behaviors outlined by Sidle (1969) and Weisman (1976). In reviewing the literature pertinent to the coping processes of the individual with cancer, the researcher became aware that no instrument existed that dealt with identifying coping styles of individuals. Many instruments were available describing general coping strategies, anxieties and attitudes toward death. However, none presented these strategies as a predominant mode of perceiving or behaving in response to a serious illness, as defined by coping styles. Therefore, it was necessary for the researcher to design the instrument for the study using the literature and various experts in oncology and crisis theory.

Pre-Pilot Testing

In preparing items for an instrument Borg and Gall (1971) suggest that the researcher ask a small number of subjects meeting the established criteria to respond to a question in essay form such as, "what did you do when the physician told you that you had cancer?" In this manner a number of items can be constructed based on the sample answers to the open-ended statements. Responses in detail are necessary to obtain information for item construction. Because it was not feasible for the researcher to do this due to a time factor, constructing the items for the instrument was accomplished through a literature review and the aid of experts in the areas of cancer and crisis theory. Item construction through the use of literature review and experts alone requires pre-testing for greater reliability and validity (Wiersma, 1975).

The initial preparation of the instrument consisted of a list of thirty items classfied as the variable "coping style." The items were divided into the categories of Vigilant Focusing, Minimization, Tackling, and Capitulating. Each of the items implied an action tendency or perception since the purpose of the instrument was to measure the <u>style</u> of coping of the individual. The items were then developed specifically for the wife, and specifically for the husband ("I do not try to forget that I have cancer," or "I do not try to forget that my wife has cancer," respectively). The items were written in a positive style: "I try to seek more information . . ." or "I will soon be able to enjoy life again." A yes-no response scale was provided for each itme to evaluate the responses ("Yes I try to seek more information" or "No I do not try to seek more information").

The instrument was then administered to three terminally ill women, and their husbands in a pre-pilot test. The purpose of the pre-pilot test was to (1) ascertain whether the content presented was measuring ccping styles--perceptions or behaviors actually encountered by the individual who is terminally ill, and her spouse; (2) determine whether or not the participants understood the items; and (3) determine whether the participants felt comfortable to respond to material somewhat personal, and stressful, regarding the issue of a terminal illness.

The three participating women met the stated criteria for selection (see Figure 5). They were aged 45, 52, and 54. The three women were patients of an oncologist from a community other than the community previously described. The women and their husbands were provided assistance while completing the instrument by the researcher if it was necessary. All three couples completed the instrument in the privacy and comfort of their own homes. The instrument took each couple approximately 10-15 minutes to complete.

During and after the administration of the instrument, the participants were encouraged to discuss any items they did not understand or to which they had difficulty in responding. The researcher noted that items written in a non-specific manner such as, "my past experiences have prepared me well for the future," were difficult for the particpants to answer. All three couples asked the researcher what she meant in the item. They stated that since the meaning was unclear, it was easier to respond "No" to the non-specific items. Aware of the biasing effect, the researcher re-stated items more specifically, giving examples when appropriate. Most of the respondents changed their responses to "Yes" following the clarification by the researcher. The researcher re-worded all items that posed difficulty for the respondents so that their concreteness enabled all study participants to understand each item.

Because the researcher and participants found that some of the items measuring each of the four coping styles were somewhat redundant, six of the items in the pre-pilot test instrument were deleted from the revised pilot instrument. Therefore the researcher reduced the number of items from thirty to twenty-four choosing only those items which appeared to more specifically measure a style of coping.

Six items were then included in each of the four categories of Vigilant Focusing, Mimimization, Tackling, and Capitulating, although these four coping styles were not labeled on the instrument itself. Another revision was made in the method of responding to the 24 items on the Coping Index. Instead of yes-no responses the Likert method was employed utilizing a four-point scale. The Likert method was chosen because the scale measures the degree of level of agreement or disagreement with items on an instrument (Wiersma, 1975). The respondents then had an opportunity to respond to each item by choosing one of the following:

Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree

The common use of the category "Undecided" was not applied in this study for the following reasons: (1) there is a tendency for some individuals to check the middle category no matter what the item relates (Bell, 1977); (2) the "Undecided" category would not allow the researcher to identify which coping style was in effect, or to what degree. The primary disadvantage of the Likert Scale is that one is never sure of the degree to which the subjects responses reflect true attitudes or feelings. However, Borg and Gall (1971) relate that the Likert Scale has a higher reliability than other scales in terms of internal consistency.

Pilot Testing

After the revisions were made in the pre-pilot instrument the refined instrument was administered in a pilot test to determine the ease of administration. Five terminally ill women and their husbands participated, aged 43-57, none of which had participated in the pre-pilot test. These were contacted via the same oncologist as in the pre-pilot test. The five women all met the criteria for selection in this study as outlined in Figure 5. The pilot test took each of the five couples approximately 7-15 minutes to complete. Each couple completed the instrument in their own homes, with the researcher present.

The pilot testing indicated that the items stated in a positive manner tended to condition the respondent to answer positively, or "Strongly Agree, Mildly Agree." Therefore twelve of the items were reworded to read negatively ("I will never get well again" instead of "I will soon get well"); twelve of the items were not revised, and remained positively stated. Also, the sequence of each item was changed so that not all six items of the four categories (Vigilant Focusing, Minimization, Tackling, and Capitulating) followed each other. These two revisions were made so that the respondents would not be influenced by the style of wording, but instead would be encouraged to think about each item prior to responding. Before the instrument could be used for data collection it was appropriate to test the instrument for reliability. The reason for this was the fact that the instrument had not been standardized, rather it was developed by the researcher through the aid of literature review and experts in cancer and crisis theory.

Reliability

Reliability as defined by Isaac (1975) means the consistency between measurements in a series. In addition, reliability refers to internal consistency of interrelatedness between the items in the instrument (Borg and Gall, 1971). A variety of methods are available for testing the reliability of an instrument. Wiersma (1975) identifies three techniques for testing reliability: Test-Retest, Alternate Forms, and Split-Half. A brief discussion of each technique and rationale for choosing one method for this study follows.

The Test-Retest Method involves the administration of the same test to a sample group more than one time, after an intervening time period. The intervening time period is necessary to reduce subject memory of the items (Borg and Gall, 1971). In the present study the Test-Retest Method was not feasible since the researcher did not have access to the same subjects for retesting at a later date. Because of the emotional nature associated with the Coping Index, it was not considered advisable for them to be asked to complete the instrument a second time. Additionally, the progression or remission of the disease process could alter the manner in which the participants could respond.

Alternate Forms Method is another technique for testing the reliability of an instrument. This method involves a second testing of the instrument (similar to the Test-Retest Method), although at the second administration a different instrument very much like the first one is administered. The Alternate Forms Method, although eliminating the memory factor of the Test-Retest Method, relies on the availability of a second instrument, similar to the original (Wiersma, 1975). Because of the inavailability of a second similar instrument, and the lack of access to the same subjects for retesting, the Alternate Forms Method was also not appropriate for this study.

A third technique described by Wiersma (1975) is the Split-Half Method for measuring reliability of an instrument. The Split-Half Method requires only one administration of the instrument. The instrument is divided into two halves, each half scored independently of the other, with the items of the two halves matched on content and difficulty. The scores of the two halves are then correlated, and this correlation coefficient is the reliability coefficient on half of the items in the instrument. The Spearman-Brown step-up (Wiersma, 1975) is used to estimate the reliability of the whole test. This formula is given by:

$$r_w = \frac{2r}{1+r} ,$$

where r_w is the reliability of the whole test, and r is the correlation between the two halves. Although the researcher felt that this method was the most feasible for testing reliability, Crano (1978) suggests the Cronbach (1970) for "Coefficient Alpha." In order to test for inter-item relatedness of the total instrument the following formula was used to determine the "Coefficient Alpha" (Cronbach, 1970):

$$r_{tt} = \frac{k}{k-1} \frac{(1-\Sigma\sigma_1^2}{\sigma_T^2}$$

where k = the number of items in the total scale
σ_T^2 = the variance of the total scale
$\Sigma\sigma_1^2$ = the sum of the variances of each item in the scale
r_{tt} = coefficient Alpha, the estimate of full scale reliability

The higher the coefficient the greater the reliability of the instrument.

In addition to testing for reliability, it is also necessary to test for the validity of the instrument, since the instrument was not standardized and had not been tested previously. Borg and Gall (1971) relate that testing the instrument for reliability only is inadequate because the instrument is capable of having a high reliability coefficient, and yet be invalid.

Validity

The validity of an instrument is defined as the extent to which an instrument measures what it is supposed to measure (Wiersma, 1975). There are various types of validity: face, predictive, content, construct, concurrent. The type of validity to be estimated is largely determined by the purpose of the instrument being tested. In this study, the researcher was only concerned with one type of validity, that of content validity. Content validity refers to the extent to which the test items reflect the academic discipline or behavior under study (in this study, Coping Styles). When dealing with feelings or opinions as in this study, the assessment of all possible responses regarding the coping processes becomes a difficult task.

Because there is no statistical technique to apply to content validity, the researcher is required to review the literature carefully prior to construction of instrument items. When the researcher is satisfied with the material obtained from the thorough review of the literature, an estimate of content validity is almost entirely dependent upon the judgment of the researcher (Borg and Gall, 1971). In the present study content validity was estimated by the subjective scrutiny of each item on the instrument by the researcher and by conferring with various cancer and crisis theory experts. The items on the instrument were estimated to be representative of behaviors or perceptions related to the coping process. Because no other measurement of validity was available, content validity by the judgment of the researcher and study-related experts provided the only method of estimating the validity of the instrument.

In summary, the discussion of the instrument has focused on the developmental aspects of the instrument, pre-pilot and pilot testing, reliability, and validity of the instrument. The data collection procedure is presented in the next section.

Data Collection Procedure

The following section presents the procedure employed in the data collection. After standardizing the criteria for selection of the population (Figure 5) and obtaining permission from the primary oncologist at the clnical site, the researcher made personal contact via the telephone with the forty-four women who met the criteria. The evening hours were utilized to make the phone calls since it was difficult to reach many of the women and their husbands at home during the day. The researcher spoke with the woman of the household, with the exception of three cases. The following format was used for each telephone contact:

1. Introduction of self by name, position, and association with the oncology clinic.

2. Explanation of the research study (see Appendix A).

3. Request for participation in the study.

    a. Complete consent form and data profile sheets via the mail by both husband and wife.
    b. Complete the 24 item questionnaire by both the husband and wife in their home with the researcher present.

4. Assure anonymity by assigning a number to each couple's Basic Data Profile Sheet and Coping Index.

5. Allow time for questions and concerns.

6. Assure the participants that they could refuse to participate.

If the woman was uncertain about participating in the study, or needed to discuss further with her husband, the researcher assured her to take the time necessary to decide on participating or not. The researcher contacted those who were hesitant within the next week to obtain a response. Twenty women consented to participate in the study out of the 44 contacted by telephone. When a couple did decide to participate in the study, the researcher followed the criteria as stated here:

1. Send the following materials to each verbally consenting couple: a letter explaining in detail the nature of the study (see Appendix A), its importance to nursing, and requirements of the participants; a consent form (see Appendix B) to be signed by both

husband and wife; and two (2) Basic Data Profile Sheets (see Appendix B), one each for the husband and wife to complete. The Basic Data Profile Sheets and consent forms were to be returned within one week's time to the researcher in the self-addressed envelope provided.

2. Schedule an appointment for a home visit within the following two weeks for the administration of the instrument, where both husband and wife had to be present to complete the instrument simultaneously.

When the Basic Data Profile Sheets and consent forms were received by the researcher in the mail, they were assigned a number (01, 02, 03, etc.) and were filed by the researcher until all data was collected from the twenty couples. The period for collecting data from the instrument (via home visits) extended from mid September to mid October. When the 20 couples had all been contacted via a home visit, and had completed the instrument, the process of scoring was initiated.

Scoring

The following section presents the procedure for scoring the completed instrument. Using the Likert scale for items 1-24, a possibility of points ranging from one to four was assigned each of the responses

Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree

depending on each item's negative or positive nature. Four points were assigned for the greatest degree of <u>disagreement</u> to a positive item, and one point for the least degree of <u>disagreement</u>. Two or three points were given for the responses mildly agree, and mildly disagree, respectively, to a positive item. For a negative item on the instrument, four points were assigned for the greatest degree of <u>agreement</u>, and one point for the least degree of <u>agreement</u>. Two or three points were given for the responses mildly disagree, and mildly agree, respectively to a negative item. For example, if the wife strongly agreed with item 1 ("I actively seek more information about my cancer") one point was given since it was a positively-stated item. If the husband strongly agreed with item 3 ("I laugh off everyone's concern about my wife's health") he received four points, since it was a negatively-state item (see Appendix C for assigned points to each response in each item).

Six items were assigned to each of the four coping styles (Vigilant Focusing, Minimization, Tackling, and Capitulating) for a total of 24 points in each category. If the individual had a score of six in any one coping style, he/she could be considered to be utilizing that coping style effectively. A sum of the scores in each coping style resulted in a Total Score for each individual, with a possible maximum score of 96. Thus if an individual had a total of 86, he/she would be considered not utilizing the four coping styles effectively. The lower the score (lowest = 24) the individual had, the better he/she was considered to be coping. Once the instrument was scored for each couple, the data were coded and then analyzed.

Data Analysis

The following section presents the procedures used for the data analysis of the study. Operational definitions of the concepts, the variables, the hypotheses and the statistical techniques used in testing the hypotheses are presented.

Operational Definitions of Concepts

Concepts of coping style (cognitive and behavioral), Vigilant Focusing, Minimization, Tackling, Capitulating, and Terminally Ill were operationally defined from the literature review in order to determine the content for the instrument. The following definitions apply in the study:

1. Coping Style is defined as the predominant use of certain defense mechanisms as well as manifestations of the individual's cognitive and perceptual styles. Coping Style is influenced by an individual's perception (cognition) and action (behavior) in response to a stressor (Lipowski, 1970).

a. Cognitive Coping Style is an individual's characteristic way of perceiving, thinking, and problem-solving in response to illness. In this study Vigilant Focusing and Minimization are examples of Cognitive Coping Style.

b. Behavioral Coping Style is the habitual mode of acting in response to illness. Predominant action tendencies, however, may be altered by factors inherent in the individual's current psychological state or other situational variables. In this study Tackling and Capitulating are examples of Behavioral Coping Style.

2. Vigilant Focusing connotes a brisk response to perceived signals of danger and persistent attempts to reduce uncertainty and ambiguity about all aspects of illness (Lipowski, 1970). Obsessional, anxiety-prone, or intellectualizing individuals characteristically use Vigilant Focusing. Vigilant Focusing, a cognitive coping style, can be viewed as a continuum, ranging from hypervigilance or exaggeration of all threats to bodily integrity, to realisitc recognition of threats and tasks, and rational planning (Lazarus, 1974). The coping style of Vigilant Focusing is measured by the following items in the instrument: 1, 15, 21, 22, 23, 24 (see Appendix C).

3. Minimization is the tendency to ignore, deny, or rationalize personal significance of information input related to one's illness and its consequences

(Lipowski, 1970). Minimization implies a continuum of cognitive disposition, ranging from total denial to reasonable doubt. A cognitive coping style, minimization is measured by the following items in the instrument: 3, 4, 5, 7, 10, 14 (see Appendix C).

4. Tackling refers to the adoption of an active attitude towards challenges and tasks posed by the illness or disability. Tackling is characterized by a range of behaviors. At one extreme the individual encounters a tendency to "fight the illness at any cost." At the other end of the spectrum the individual's behavior is rational and directed toward the current demands of the illness. The tackling actions are aimed at prompt recovery, or at least compensation for a disability (Lipowski, 1970). A behavioral coping style, tackling is measured by the following items in the instrument: 2, 6, 9, 18, 19, 20 (see Appendix C).

5. Capitulating is characterized by passivity. Either a withdrawal from, or a clinging to others commonly occurs. Persons employing this coping style demonstrate very little initiative or action to fight the illness. Lipowski (1970) relates that a degree of passive giving in or withdrawal can be the most adaptive form of behavior, especially during the acute stages of a serious illness. When the individual continually uses capitulating, however, the coping style is no longer

effective. The behavioral coping style of capitulating is measured by the following items in the instrument: 8, 11, 12, 13, 16, 17 (see Appendix C).

6. Terminally Ill refers to the wife who has an incurable cancer, and who is facing impending death. Only women who were diagnosed as terminally ill, and their husbands completed the instrument for the study. The women who were identified as terminally ill met one or more of the following criteria: (1) were diagnosed as "terminally ill" by a physician, as written in the patient's medical record; (2) were diagnosed as having "widespread metastatic disease" by a physician, as written in the patient's medical record; (3) as evidenced by laboratory and radiology reports indicating "widespread metastatic disease" found in the patient's medical record.

With the concepts defined operationally, the variables of focus were determined.

The Variables

The present study, descriptive in nature, involved four variables: Cognitive Coping Style, Behavioral Coping Style, Coping Style (Total), and Husband and Wife. The only qualitative varible was the husband and wife, the other three variables being quantitative. Cognitive Coping Style and Behavioral Coping Style were further divided into two subvariables each: Vigilant Focusing and Minimization, and Tackling and Capitulating, respectively. Adding the four subvariables of Cognitive and Behavioral Coping Styles, the resulting number of variables for data analysis in the study was nine. Hypotheses were then developed employing the variables Cognitive Coping Style, Behavioral Coping Style, Coping Style (Total), and Husband and Wife, and the subvariables.

The Hypotheses

From the research questions stated in Chapter I and from the variables determined above the following hypotheses were tested by the study:

Hypotheses:	Variables Represented:
I. There is no statistically significant difference between the Coping Style (Total) of husbands and wives, when the wife is terminally ill.	Coping Style (Total), Cognitive Coping Style, Behavioral Coping Style, Husband and Wife.
II. The Cognitive Coping Styles of the husband and wife will be similar.	Cognitive Coping Style, Vigilant Focusing, Minimization, Husband and Wife.
III. The Behavioral Coping Styles of the husband and wife will be similar.	Behavioral Coping Style, Tackling, Capitulating, Husband and Wife.
IV. The Coping Style (Total) of the wife who is terminally ill and that of her husband can be identified.	Coping Style (Total), Cognitive Coping Style, Behavioral Coping Style, Husband and Wife.

The hypotheses were then tested for statistical significance.

The Statistical Techniques

In the following section the techniques used to test each hypothesis are presented. In Hypothesis I the differences between the mean scores of Coping Style (Total) of husband and wife is presented. In Hypothesis II the differences between mean scores of the two Cognitive Coping Styles of husband and wife is presented. Hypothesis III is concerned with the differences between the mean scores of the two Behavioral Coping Styles of husband and wife. Hypothesis IV was not tested statistically but was analyzed by frequency counts of each of the items for each subvariable.

In a descriptive study where a determination of differences between means needs to be identified, as in three of the hypotheses above, the data are analyzed by the t-test (Isaac and Michael, 1975). The t-test is particularly appropriate for small samples (less than thirty). The t-test makes two assumptions about the data obtained. The first assumption is that scores form an interval or ratio scale of measurement. The scores obtained in this study form an interval scale. The second assumption is that there is an equality of population variance with an equal μ in each group. There are twenty couples, two in each group, one husband and one wife. Hypotheses I, II, III were tested using the t-test. The statistical formula for the t-test is as follows (Isaac and Michael, 1975):

1. Determine the means and sum of the squares, Σd_1^2, for each of the two samples in question (husbands and wives).
2. Determine the t-ratio

$$t = \frac{m_1 - m_2}{\sqrt{\left(\frac{\Sigma d_1^2 + \Sigma d_2^2}{N_1 + N_2 - 2}\right)\left(\frac{N_1 + N_2}{N_1 N_2}\right)}}$$

3. Determine degrees of freedom df.

$$df = N_1 + N_2 - 2$$

4. Enter appropriate table to determine whether the t-ratio indicates a significant difference between the two samples (husbands and wives).

Figure 6.--Statistical Formula for the t-Test.

The test results to determine the difference of means between the variables in hypotheses I, II, and III are presented in Chapter V.

Human Rights Protection

The measures taken to ensure that the rights of the participants were protected is presented in this section. To ensure protection of the rights of the individuals in the study measures were taken such as providing them with the information that the study was supported by the physicians in the oncology clinic, providing assistance when needed while they completed the instrument, and informing the participants that they had a right to refuse to participate. The participation was voluntary with written consent obtained by all participants. Anonymity was provided by assigning an identification number to their Basic Data Profile Sheets and instrument rather than a name. For a complete review of the Human Rights Protection Procedures see Appendix D.

Chapter IV has provided an overview of the methodology and procedures involved in the study. The discussion has included a presentation of the population, a description of the setting, the development of the instrument, the data collection procedure, scoring, data analysis techniques, and human rights protection. In Chapter V the data is presented. Analysis of data is directed toward the hypotheses for the study.

CHAPTER V

DATA PRESENTATION AND ANALYSIS

Overview

In this chapter the data are focused on the expressed coping styles of the husband and wife when the wife is terminally ill. The findings are presented based on the data collected from 20 couples at one oncology clinic in an urban community. The data describe the differences in means between: the Coping Styles (Total); the Cognitive Coping Styles (Vigilant Focusing and Minimization); and the Behavioral Coping Styles (Tackling and Capitulating) of husbands and wives. The findings are presented in the following manner:

1. Descriptive Findings of the Population
2. Data Presentation for Hypotheses
    a. Differences in means between the Coping Styes (Total) of husband and wives (Hypothesis I).
    b. Differences in means between the Cognitive Coping Styles of husbands and wives (Hypothesis II).
    c. Differences in means between the Behavioral Coping Styles of husbands and wives (Hypothesis III).
    d. Descriptive findings of population coping styles (Hypothesis IV).
3. Reliability of Instrument
4. Summary of the chapter

To test Hypotheses I through III, the differences in means between the Coping Styles (Total), the Cognitive Coping Styles, and the Behavioral Coping Styles of husbands and wives were analyzed using the statistical technique of the t-test for small samples. To test for the reliability of the instrument,the statistical formula of Coefficient Alpha was used.

Descriptive Findings of the Population

The study population consisted of twenty terminally ill women and their husbands. The researcher obtained a list of names of all those who were seen and treated in the clinic from the secretary in the oncology clinic. This list not only included the name of men and women, but their birth date, telephone number, address, and patient identification number. From this list, the researcher identified only women who met the age criterion, since no other criteria called for were available on the list. Eighty-four women who met the age criterion were identified.

The researcher then obtained permission from the primary oncologist in the clinic to review the medical records of these 84 women. Permission was also granted by the head of medical records in the health care facility. In order to obtain the medical records, a requisition form needed to be completed by the researcher for each of the 84 records. Upon receipt of the medical records, the researcher systematically reviewed each one for the other four criteria (See Figure 5). The face sheet in the medical records contained two of the criteria required: marital status and a signed consent form that indicated willingness to participate in research. If the woman did not have a husband, or did not consent to participate in research, she was eliminated from the population. However, if these same two criteria were met as described in Figure 5, the researcher determined the diagnosis of terminally ill from one or more of 3 criteria: (1) diagnosed as "terminally ill" by a physician, as written in the medical record; (2) diagnosed as having "widespread metastatic disease" by a physician, as written in the patient's medical record; (3) as evidenced by laboratory and radiology reports indicating "widespread metastatic disease" found in the patient's medical record. The final criterion of literacy with the English language was obtained from the patient's history in the medical record.

Forty-four women who met all the criteria were identified from the medical records. All of these women were patients of the same group of physicians in the oncology clinic, and followed specific detailed protocols. By studying a small sample in one particular setting a a degree of extraneous variable interference was minimized. The varying ideas and treatment of health care providers in other settings in the community may have had an impact on the coping styles of given individuals.

Twenty women and their husbands agreed to participate in the study. These women met all the criteria outlined in Chapter IV (see Figure 5). All of the study participants were Caucasian, and were Protestant, with the exception of six couples who were Catholic. The following demographic data was compiled from the Basic Data Profile Sheets that each of the twenty husbands and wives had to complete as part of the research study.

Age

The mean age of both husbands and wives (N = 40) was calculated as 52.27 years. The age of the women ranged from 40-62, while their husbands ranged from 40-65. The mean age of women (N = 20) was 51 years, and that of the men (N = 20), 53 years.

Education

The mean level of education of both husbands and wives (N = 38) was that of 12 years, or completion of high school. The frequency distribution of husbands and wives and the level of education is presented in Table 1.

Table 1.--Sex and Level of Education of the Study Population (N = 38)

Level of Education	Men	Women	Total
Grade 1-8	1	0	1
Not Completed High School	2	4	6
High School Completed	6	9	15
College Completed	3	7	10
Advanced Degree	6	0	6
Total	18	20	38

One man in the study population had completed only grades 1-8. Four women and two men had not completed high school. The majority of the total population, six men and nine women had completed high school, while three men and seven women had obtained a college degree. Six of the men and no women indicated that they had an advanced degree. Two of the men did not respond to this question on the Basic Data Profile Sheet (see Appendix B).

Income

The mean income was calculated as between \$20-24,000 (N = 16). The frequency distribution of the level of income is presented in Table 2.

Table 2.--Number of Couples in the Study Population According to Level of Income (N = 16)

Level of Income	Number of Couples
1,000-4,999	0
5,000-9,999	2
10,000-14,999	1
15,000-19,999	0
20,000-24,999	2
25,000 and Over	11
Total	16

There were no couples in the study population who indicated that their mean family income was below 5,000 and there were no couples who indicated that their income ranged between 15,000-19,999. Only 2 couples responded that 5,000-9,999 was their mean family income, and 1 couple indicated 10,000-14,999. Two couples indicated that their income was no less than 21,000. The majority of the population (11) indicated that the mean family income was 25,000 and over. Four couples did not indicate their income level on the Basic Data Profile Sheet (see Appendix B).

Occupation

Seven categories were provided for the study participants to choose from in the area of occupation. They were the following: Housewife, Clerical, Professional, Self-Employed, Skilled Worker, Retired, and Other. The following frequency table provides the distribution of each category according to sex.

Table 3.--Sex and Occupation of the Study Population (N = 40)

Occupation	Men	Women	Total
Housewife	0	13	13
Clerical	0	3	3
Professional	9	1	10
Self-Employed	3	0	3
Skilled Worker	1	1	2
Retired	3	1	4
Other	4	1	5
Total	20	20	40

Thirteen of the wives were housewives, and did not work outside the home; three women were employed where clerical skills were needed. Only one woman had a professional career, while nine men were considered professionals. Three men were self-employed, one man and one woman were skilled workers. Three men and one woman were retired. Four men and one woman indicated that they were employed in an "other" category, whereby each specified their occupation. The specified occupations were the following: government employee, factory worker (2), reliability engineer, and an underwriter.

Years of Marriage

Each couple was asked to indicate the number of years of marraige. The mean years of marriage of the couples (N = 19) was calculated as 27 years. Only one couple did not indicate total years of marriage on the Basic Data Profile Sheet.

Date of Diagnosis

Each woman was asked to indicate the date of diagnosis of the cancer. The mean date of diagnosis of the women (N = 20) was calculated as between 12 and 18 months from the date that the Basic Data Profile Sheet was completed. The length of time that the women had been diagnosed as having cancer ranged from 0-6 months to 30-36 months. The frequency distribution of women and the date of diagnosis is presented in Table 4.

Table 4.--Number of Women and the Date of Diagnosis of Cancer (N = 20)

Length of Diagnosis	Number of Women
0-6 months	5
7-12 months	3
13-18 months	5
19-24 months	2
25-30 months	2
31-36 months	3
Total	20

Five women in this study had been diagnosed less than 6 months. Three women had been diagnosed between 6-12 months ago, while 5 had been diagnosed between one year and 18 months. Two women had been diagnosed in each of the categories 18-24 months and 24-30 months. Three women had been diagnosed between thirty and thirty-six months.

Type of Cancer of the Women

Each woman in the study was asked to indicate what type of cancer with which they had been diagnosed. The frequency distribution of the primary lesion of cancer is presented in Table 5.

Table 5.--Number of Women in the Study According to Type of Cancer (N = 20)

Type of Cancer	Number of Women
Breast	13
Lung	2
Leukemia	1
Ovary	3
Lymphoma	1
Total	20

Thirteen of the twenty women in the study population had cancer of the breast with widespread metastasis. Two of the women were diagnosed with the primary lesion in the lung, while three had cancer of the ovary, both with advanced disease. Only one woman had leukemia, and one with lymphoma; which were both in the terminal phases.

Type of Treatment

The type of treatment that the twenty women were receiving was categorized into eight responses: chemotherapy; radiology; surgery; other; or combinations of the three: chemotherapy and surgery; chemotherapy and radiology; radiology and surgery; or all. The frequency distribution which best describes the study population is presented in Table 6.

Table 6.--Number of Women in the Study According to Type of Treatment (N = 20)

Type of Treatment	Number of Women
Chemotherapy	4
Radiology	0
Surgery	0
Other	1
Chemotherapy/Radiology	1
Radiology/Surgery	2
Chemotherapy/Surgery	6
All of the Above	6
Total	20

Four of the women indicated that they received chemotherapy as the only means of treatment for their cancer. None of the women responded that they received only radiology, or only surgery as the means of treatment. One woman responded in the other category, but did not relate what this treatment was. Only one woman indicated that chemotherapy and radiology used in combination was the treatment she received. Two of the women received radiology and surgery for their combined treatment. Six of the women indicated that they received a combination of surgery and chemotherapy, and six responded that all treatments were used to combat their cancer. Thus 17 women indicated that they received chemotherapy for at least part of their treatment.

Number of Children in the Family

The mean number of children in the family among the 20 couples was calculated at 3.2 children. The range extended from 1 to 6 children in the family.

Number of Children Living at Home

The mean number of children still living at home among the 20 couples was calculated at 1.0. The range extended from 0 to 4, with 9 of the couples indicating that no children were still living at home. Thus, half of the couples had at least 1 child at home.

Summary

The preceding section has presented the descriptive findings of the study population. The specific characteristics of the population described were: Age, Education, Income, Occupation, Date of Diagnosis, Type of Cancer of the Women, Type of Treatment of the Cancer, Number of Children in the Family, and Number of Children Still Living at Home.

The following section presents the data for the research hypotheses. Specifically, the hypotheses focused on the differences in means between: the Coping Styles (Total) of husbands and wives; the Cognitive Coping Styles of husbands and wives; the Behavioral Coping Styles of husbands and wives; and the nature of the population Coping Styles.

Data Presentation for Hypotheses

Hypothesis I

> There is no statistically significant difference between the expressed Coping Styles (Total) of the husband and wife when the wife is terminally ill.

Coping Style, as operationalized in Chapter I, is the predominant use of certain defense mechanisms as well as manifestations of the individual's cognitive and perceptual styles. Therefore, coping style is composed of, and influenced by, an individual's perception (cognition) and action (behavior) in response to a stressor.

Cognitive Coping Style is an individual's characteristic way of perceiving, thinking, and problem-solving in response to illness. Vigilant Focusing and Minimization are the two Cognitive Styles under study.

Behavioral Coping Style is an individual's mode of acting in response to illness. Predominant action tendencies may be altered by factors inherent in the individual's current psychological state and by other situational variables. Tackling and Capitulating are the two Behavioral Coping Styles under study.

The two components of Coping Style (Total) were analyzed for husbands and wives, and the means obtained. The Coping Style (Total) means were then obtained by adding the mean scores of Cognitive, and the mean score of Behavioral Coping Styles for husbands and wives (see Table 7).

Table 7.--Mean Scores of Husbands and Wives for Coping Styles (Total), Cognitive Coping Style, Behavioral Coping Style, and t-values at .05 Level of Significance (N = 40)

Coping Style	Husbands	Wives	t-value
Cognitive Coping Style	23.70	27.20	-1.79
Behavioral Coping Style	19.75	18.85	.32
Coping Style (Total)	43.45	46.05	-1.31

The mean score for husbands' Cognitive Coping Style was calculated as 23.70, and for the Behavioral Coping Style, 19.75. The mean score for the wives' Cognitive Coping Style was calculated as 27.20, and for the Behavioral Coping Style, 18.85. The sum of the Cognitive and Behavioral Coping Styles provided the means for the Coping Style (Total) of husbands (43.45) and wives (46.05). Using the Coping Style (Total) means, the t-value was then calculated as -1.31 which was not significant at the .05 level. Therefore, the null hypothesis was not rejected, and the differences in means can be attributed to chance.

Hypothesis II

> There is no statistically significant difference between the expressed Cognitive Coping Styles (Vigilant Focusing and Minimization) of the husband and wife when the wife is terminally ill.

Cognitive Coping Style is an individual's characteristic way of perceiving, thinking, and problem-solving in response to illness. The two Cognitive Coping Styles under study are Vigilant Focusing and Minimization.

Vigilant Focusing connotes a brisk response to perceived signals of danger and persistent attempts to reduce uncertainty and ambiguity about all aspects of illness. Vigilant Focusing ranges from hypervigilance or exaggeration of all threats to bodily integrity, to realistic recognition of threats, and rational planning.

Minimization is the tendency to ignore, deny, or rationalize personal significance of information input related to one's illness and its consequences. Minimization Coping Style ranges from total denial to reasonable doubt.

The two forms of Cognitive Coping Style were analyzed for husbands and wives, and the means obtained. The Cognitive Coping Style (Total) means were then obtained by adding the mean score of Vigilant Focusing, and the mean score of Minimization Coping Styles for husbands and wives (see Table 8).

Table 8.--Mean Scores of Husbands and Wives for Cognitive Coping Style (Total), Vigilant Focusing, Minimization Coping Styles, and t-values at the .05 Level of Significance (N = 40)

Coping Style	Husbands	Wives	t-value
Vigilant Focusing	13.35	14.30	-1.07
Minimization	10.35	12.90	-3.34
Cognitive Coping Style (Total)	23.70	27.20	-1.79

The mean score for husbands' Vigilant Focusing Coping Style was calculated as 13.35. The mean score for the wives' Vigilant Focusing Coping Style was calculated as 14.30. A t-value of -1.07 was then calculated for the differences in means between husbands and wives. This t-value of -1.07 was not significant at the .05 level of confidence. Therefore, there was no significant difference between husband and wife Vigilant Focusing Coping Styles. The null hypothesis was not rejected.

The mean score for husbands' Minimization Coping Style was calculated as 10.35. The mean score for wives' Minimization Coping Style was calculated as 12.90. A t-value of -3.34 was then calculated for the differences in mean scores between the husbands and wives. This t-value of -3.34 was significant at the .05 level of confidence. The null hypothesis was thus rejected, since there was a difference between the husbands and wives on the Coping Style Minimization.

The Cognitive Coping Style (Total) of 23.70 for the husbands was determined by calculating the sum of the means for Vigilant Focusing for Minimization. The Cognitive Coping Style (Total) of 27.20 for wives was determined by calculating the sum of the means for Vigilant Focusing and for Minimization. A t-value of -1.79 was then calculated, which was not significant at the .05 level of confidence. The null hypothesis could not be rejected because there was no significant difference between husbands and wives on the Cognitive Coping Style scale.

Hypothesis III

> There is no statistically significant difference between the expressed Behavioral Coping Styles (Tackling and Capitulating) of the husband and wife when the wife is terminally ill.

Behavioral Coping Style is an individual's mode of acting in response to illness. The two Behavioral Coping Styles under study are Tackling and Capitulating.

Tackling implies adopting an active attitude towards challenges and tasks posed by illness or disability. Tackling Coping Style ranges from "fighting the illness at any cost" to rational behavior directed toward the current demands of the illness.

Capitulating is characterized by passivity, and either withdrawal from or dependent clinging to others. Little observable initiative or action to combat illness and achieve maximum possible recovery is displayed by the individual using this coping style.

The two forms of Behavioral Coping Style were analyzed for husbands and wives, and the means obtained. The Behavioral Coping Style (Total) mean was then obtained by adding the mean score of Tackling, and the mean score of Capitulating for husbands and wives (see Table 9).

Table 9.--Mean Scores of Husbands and Wives for Behavioral Coping Style (Total), Tackling, Capitulating Coping Styles, and t-values at .05 Level of Significance (N = 40)

Coping Style	Husbands	Wives	t-value
Tackling	10.75	10.30	.38
Capitulating	9.00	8.55	.44
Behavior Coping Style (Total)	19.75	18.85	.32

The mean score for the husbands' Tackling Coping Style was calculated as 10.75. The mean score for wives' Tackling Coping Style was calculated as 10.30. A t-value of .38 was then calculated for the differences in means between husbands and wives. This t-value of .38 was not significant at the .05 level of confidence. Therefore, there was no significant difference between the husbands' and wives' Tackling Coping Style. The null hypothesis was not rejected.

The mean score for the husbands' Capitulating Coping Style was calculated as 9.00. The mean score for wives' Capitulating Coping Style was 8.55. A t-value of .44 was then calculated for the differences in mean scores between husbands and wives. This t-value of .44 was not significant at the .05 level of confidence. Therefore, the null hypothesis could not be rejected since there was essentially no significant difference between the husbands' and wives' Capitulating Coping Style.

The Behavior Coping Style (Total) of 19.75 for husbands was determined by calculating the sum of the means for Tackling and Capitulating. The same procedure was used to calculate the wives' Behavioral Coping Style (Total) of 18.85. A t-value of .32 was then calculated, which was not significant at the .05 level of confidence. The null hypothesis could not be rejected because there was no significant difference between the husbands' and wives' Behavioral Coping Style (Total).

Hypothesis IV

> The coping styles of husband and wife, when the wife is terminally ill, can be identified.

The above hypothesis, for descriptive analysis, was divided into four parts each of which is discussed separately. The four parts are Vigilant Focusing, Minimization, Tackling, and Capitulating.

Vigilant focusing.--The items on the instrument (see Appendix C) measuring the Cognitive Coping Style of Vigilant Focusing were:

Item 1. I actively seek more information about my cancer (my wife's cancer)*

*Husbands' responses on the Coping Index.

Item 15. I confront the doctors to answer my questions concerning my illness (my wife's illness)*

Item 21. Things would be a lot better if my family and friends would talk openly with me about my cancer (my wife's cancer)*

Item 22. Things would be better if the doctor would talk with me more about my illness (my wife's illness)*

Item 23. Things would be better if I knew where I could get financial help

Item 24. My husband (wife)* and I should get professional counseling

In Table 10 the frequency distributions of how husbands and wives responded to the Vigilant Focusing items (1, 15, 21, 22, 23, 24) of the instrument are presented. Both husbands (19) and wives (18) agreed to some degree to Item 1 that they were actively seeking more information about cancer (see Appendix C). Only one husband strongly disagreed, while two wives mildly disagreed. Of the total group of husbands (N = 20), 19 (95 percent) either strongly agreed or mildly agreed to "actively seeking information" indicating that they were using the Vigilant Focusing Coping Style. Of the total group of wives (N = 20), 18 (90 percent) either strongly agreed or mildly agreed to this item, again indicating that they were using the Coping Style Vigilant Focusing.

*Husbands' responses on the Coping Index.

Table 10.--Number of Individuals Identifying Degree of Agreement According to Item for Vigilant Focusing Coping Style (N = 20 couples), where H = Husbands and W = Wives

Item		Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree
Seek Information (1)	H	12	7	0	1
	W	11	7	2	0
Confront Doctor (15)	H	10	6	1	2
	W	10	6	2	2
Talk Openly with Others (21)	H	4	8	4	4
	W	7	5	3	5
Talk with Doctor (22)	H	11	4	2	3
	W	7	6	2	5
Financial Help (23)	H	6	1	6	7
	W	2	4	7	7
Professional Counseling (24)	H	1	2	6	11
	W	2	1	6	11

Both husbands (16) and wives (16) responded to some degree that they were confronting the doctor to answer questions concerning the illness (see Appendix C, Item 15). Only one husband mildly disagreed, and two strongly disagreed with this item. One husband did not answer this item on the instrument. Two wives strongly disagreed, and two mildly disagreed with Item 15. Of the total group of husbands (N = 19), 16 (84 percent) either agreed mildly or strongly to Item 15. Of the total group of wives (N = 20), 16 (80 percent) either strongly or mildly agreed to this item. These results indicate that Vigilant Focusing was also in use for both husbands and wives to the same degree.

The responses to "Things would be better if my family and friends would talk openly with me about cancer" (see Appendix C, Item 21), again indicated that both husbands (12) and wives (12) agreed to some degree to this item. Four husbands and three wives mildly disagreed to Item 21, while four husbands and five wives strongly disagreed with the item. Of the total group of husbands (N = 20), 12 (60 percent) either agreed strongly or mildly to the item "things would be better if my family and friends would talk openly with me about cancer." Of the total group of wives (N = 20), 12 (60 percent) either mildly or strongly agreed to Item 21 also.

In Item 22, the husbands (15) and wives (13) responded that they agreed to some degree to, "things would be better if the doctor would talk with me more about the illness" (see Appendix C). Of the total group of husbands (N = 20), 15 (75 percent) either agreed mildly or strongly with this item. Of the total group of wives (N = 20), 13 (65 percent) either agreed mildly or strongly with the item. Two husbands and two wives mildly disagreed to this item, while three husbands and five wives strongly disagreed.

Only seven husbands and six wives agreed to some degree with the item that stated that things would be better if they knew where to get financial help (see Appendix C, Item 23). Of the total group of husbands (N = 20), 7 (35 percent) agreed mildly or strongly that financial help was needed; and of the total group of wives (N = 20), 6 (30 percent) agreed strongly or mildly to this item. Thirteen (65 percent) husbands, and fourteen (70 percent) wives disagreed mildly or strongly to the statement, indicating that Vigilant Focusing was not in use in regards to financial help.

Both husbands (17) and wives (17) disagreed to some degree that professional counseling should be sought (see Appendix C, Item 24). Only 3 husbands and 3 wives either mildly or strongly agreed to this item, indicating that professional counseling was not perceived as needed.

Of the total group of husbands (N = 20) and wives (N = 20) 17 (85 percent) respectively disagreed with the item.

In summary, items 1, 15, 21 indicated that both husbands and wives were Vigilant Focusing. Items 21, 23, and 24 did not indicate Vigilant Focusing, however, both husbands and wives responded in the same manner to these three items.

Minimization.--The items on the instrument (see Appendix C) measuring the Cognitive Coping Style of Minimization were:

Item 3. I laugh off everyone's concern about my health (my wife's health)*

Item 4. I try to forget I have cancer (my wife has cancer)*

Item 5. I spend time at little tasks to keep me from thinking about my illness (my wife's illness)*

Item 7. There is something good about having cancer (my wife having cancer)*

Item 10. I reduce tension I have by overeating, overdrinking, and/or excess drug usage

Item 14. I will soon be just as good as before (my wife will be . . .)*

In Table 11 the frequency distribution of how husbands and wives responded to the Minimization items

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*Husbands' responses on the Coping Index.

Table 11.--Number of Individuals Identifying Degree of Agreement According to Number for Minimization Coping Style (N = 20 couples), where H = Husbands and W = Wives

Item		Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree
Laugh off Concerns (3)	H	1	0	2	17
	W	4	3	6	7
Try to Forget Cancer (4)	H	2	4	3	11
	W	5	4	7	3
Spend Time at Little Tasks (5)	H	3	5	3	9
	W	7	4	4	5
Reduce Tension by Excessive Intake of Substances (10)	H	0	1	4	15
	W	0	0	2	18
Soon be Good as Before (14)	H	6	5	4	5
	W	5	7	4	4

(3, 4, 5, 7, 10, 14) of the instrument are presented. Nineteen husbands disagreed to some degree with the statement "I laugh off everyone's concern about my wife's illness" (see Appendix C, Item 3). Only 13 of the wives disagreed to some degree to the same statement about their illness. Seven wives and only one husband either mildly or strongly agreed to this item. Of the total group of husbands (N = 20), 19 (95 percent) either strongly or mildly disagreed ot Item 3, indicating that they were not minimizing their wives' illness. However, of the total group of wives (N = 20), 13 (65 percent) either strongly disagreed or mildly disagreed to the same item, indicating that they were minimizing 30% more than their husbands.

In Item 4, 14 husbands disagreed to some degree with the statement, "I try to forget my wife has cancer" (see Appendix C). Ten of the wives disagreed to the same statement about themselves. Only six of the husbands agreed to some degree with this item, while nine of the wives agreed to the same item to some degree. Of the total group of husbands (N = 20), 14 (70 percent) either strongly or mildly disagreed to Item 4, indicating that again they were not minimizing their wives' illness. Of the total group of wives (N = 20), 10 (50 percent) either strongly or mildly disagreed to the same item.

The item stating, "I spend time at little tasks to keep me from thinking about my illness (my wife's illness)* (see Appendix C, Item 5), indicates that

*Husbands' response to Coping Index.

12 husbands disagreed to some degree to the statement, while 9 wives disagreed to the same statement. Eight husbands agreed to some degree, and 11 wives agreed to the same statement, either mildly or strongly. Of the total group of husbands (N = 20), 12 (60 percent) disagreed to this item. Of the total group of wives (N = 20), 9 (45 percent) disagreed to the same item, indicating that more than half of the wife population (55 percent) were minimizing their illness related to Item 5.

Eighteen of the husbands (90 percent) disagreed to some degree to the item, "there is something good about having cancer" (see Appendix C, Item 7). Thirteen (68 percent) of the total group of wives (N = 19) disagreed to some degree to this item. Only two of the husbands agreed to the statement, while six of the wives agreed either mildly or strongly to the same item. Again this indicates that the wives in this study were minimizing their illness more than their husbands.

To the statement, "I reduce tension by overeating, overdrinking, and/or excess drug usage," (see Appendix C, Item 10) 19 (95 percent) of the husbands and 20 (100 percent) of the wives disagreed with the statement. Only one husband mildly agreed with this item. Both husbands and wives indicated nearly a non-existent degree of minimization on this particular item.

Both husbands (11) and wives (12) agreed to some degree to the statement "I will soon be just as good as before (my wife will be . . .)*" (see Appendix C, Item 14). Nine husbands and eight wives disagreed to the statement. Of the total group of wives (N = 20), 12 (60 percent) agreed either mildly or strongly to this item. Of the total group of husbands (N = 20), 11 (55 percent) agreed either mildly or strongly to the same item. These findings suggest that the wives in this study minimized their illness by 5% greater than their husbands on this particular item.

In summary, items 3, 4, 5, 7, and 14 indicated that the husbands minimized less than their wives. Only in Item 10 did both husbands and wives indicate that minimization was not a part of their coping style repertoire. This data is valuable in explaining Hypothesis II as well as Hypothesis IV.

Tackling.--The items on the instrument (see Appendix C) measuring the Behavioral Coping Style of Tackling were:

Item 2. I talk with others to relieve distress

Item 6. I follow my doctor's orders (encourage my wife to follow . . .)*

Item 9. I work out good alternatives to some of my plans affected by my illness (my wife's illness)*

*Husbands' responses to Coping Index.

Item 18. I look forward to the future

Item 19. I will fight my illness any way I can (my wife's illness)*

Item 20. I can look forward to more good times than bad (with my wife)*

In Table 12 the frequency distribution of how husbands and wives responded to the Tackling items (2, 6, 9, 18, 19, 20) of the instrument are presented. Eighteen of the husbands (90 percent) agreed either mildly or strongly to the statement, "I talk with others to relieve distress" (see Appendix C, Item 2). Thirteen of the wives (65 percent) agreed to the same statement. Only two of the husbands disagreed with the item, while seven of the wives disagreed either mildly or strongly to Item 2.

Both husbands (20) and wives (19) agreed to the statement, "I follow my doctor's orders (encourage my wife to follow . . .)"* (see Appendix C, Item 6). Only one wife disagreed mildly with this item. Of the total group of husbands (N = 20), 20 (100 percent) agreed to Item 6. Of the total group of wives (N = 20), 19 (95 percent) agreed to the same item. This data indicates essentially identical Tackling Coping Styles to this particular item.

*Husbands' responses to Coping Index.

Table 12.--Number of Individuals Identifying Degree of Agreement According to Item for Tackling Coping Style (N = 20 couples), where H = Husbands and W = Wives

Item		Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree
Talk with Others (2)	H	14	4	1	1
	W	4	9	4	3
Follow Doctor's Orders (6)	H	16	4	0	0
	W	17	0	0	3
Work out Good Alternatives (9)	H	11	5	1	3
	W	7	10	0	3
Look Forward to Future (18)	H	10	5	3	2
	W	15	3	0	2
Fight Illness (19)	H	9	5	3	3
	W	11	1	5	3
Look Forward to More Good Times (20)	H	15	1	2	2
	W	13	4	1	2

To the statement, "I work out good alternatives to some of my plans affected by my illness (my wife's illness)"* (see Appendix C, Item 9), 16 (80 percent) of the husbands, and 17 (85 percent) of the wives agreed. Of the total group of husbands (N = 20) only four disagreed to Item 9. Of the total group of wives (N = 20) three disagreed to the same item.

To the statement, "I look forward to the future" (see Appendix C, Item 18) 15 husbands and 18 of the wives agreed to some degree. Five of the husbands, and two of the wives disagreed either mildly or strongly. Of the total group of husbands (N = 20), 15 (75 percent) agreed that they "look forward to the future." Of the total group of wives, 18 (90 percent) agreed to the same statement.

Fourteen of the husbands and twelve of the wives agreed with the statement, "I will fight my illness any way I can (my wife's illness)"* (see Appendix C, Item 19). Six of the husbands and eight of the wives disaagreed with this item. Of the total group of husbands (N = 20), 14 (70 percent) agreed with the statement. Of the total group of wives (N = 20) 12 (60 percent) agreed with the same statement.

*Husbands' response to the Coping Index.

The final item related to Tackling, "I can look forward to more good times than bad (with my wife)"* (see Appendix C, Item 20), indicated that 16 of the husbands and 17 of the wives agreed with the item. Four husbands and three wives disgreed either mildly or strongly to Item 20. Of the total group of husbands, 16 (80 percent) agreed, and of the total group of wives, (85 percent) agreed with the statement. This data indicates that both husbands and wives are using Tackling Coping Style to nearly the same extent.

In summary, items 6, 9, and 20 indicate that husbands and wives were tackling quite similarly (5 percent differences in each item). Item 18 indicated that wives (90 percent) "look forward to the future" more than their husbands (75 percent). Item 19 indicated that husbands (70 percent) responded that they would "fight their wife's illness any way I can," while 60 percent of the wives responded the same way. Finally, item 2 indicated that husbands (90 percent) "talked to others to relieve distress," while only 65 percent of the wives responded in the same way. These data are valuable in terms of the insight toward nursing intervention for couples experiencing a terminal illness of the wife.

*Husbands' response to the Coping Index.

Capitulating.--The items on the instrument (see Appendix C) measuring the behavioral coping style of capitulating were:

Item 8. I will die soon of cancer (my wife will die soon of cancer)*

Item 11. I hate to attend social gatherings because of my illness (my wife's illness)*

Item 12. I will never get well (my wife will never get well)*

Item 13. I will never be able to enjoy life again (my wife will never enjoy life again)*

Item 16. I might as well give up because I can't make things better for myself (for my wife)*

Item 17. My future seems dark to me (my wife's future)*

In Table 13 the frequency distribution of how husbands and wives responded to the capitulating items (8, 11, 12, 13, 16, 17) of the instrument are presented. To the statement, "I will die soon of cancer (my wife will die soon of cancer)"* (see Appendix C, Item 8), 17 of the husbands and 16 of the wives disagreed. Three husbands and three wives agreed either mildly or strongly to the item; one wife did not respond to item 8. Of the total group of husbands (N = 20), 17 (85 percent) disagreed with the statement that their

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*Husbands' response to the Coping Index.

Table 13.--Number of Individuals Identifying Degree of Agreement According to Item for Capitulating Coping Style (N = 20), where H = Husbands and W = Wives

Item		Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree
Die Soon (8)	H	2	1	4	13
	W	2	1	1	15
Hate to Attend Social Gatherings (11)	H	0	3	1	16
	W	2	3	3	16
Never Get Well (12)	H	3	2	0	15
	W	0	3	5	12
Never Enjoy Life Again (13)	H	2	1	1	16
	W	1	1	2	16
Give Up (16)	H	0	1	1	18
	W	0	0	2	18
Future Seems Dark (17)	H	3	0	6	11
	W	0	3	2	15

wife would die soon of cancer. Of the total group of wives (N = 19), 16 (84 percent) disagreed to the same statement.

Both husbands (17) and wives (15) disagreed to the item, "I hate to attend social gatherings because of my illness (my wife's illness)"* (see Appendix C, Item 11). Three of the husbands and five of the wives (only 2 strongly agreed) agreed with the statement. Of the total group of husbands (N = 20), 17 (85 percent) disagreed that they hated to attend social gatherings. Of the total group of wives (N = 20), 15 (75 percent) disagreed with the same statement.

Fifteen (75 percent) of the husbands (N = 20) and 17 (85 percent) of the wives (N = 20) disagreed with the statement "I will never get well (my wife will never get well)"* (see Appendix C, Item 12). Five of the husbands and three of the wives agreed either mildly or strongly to this item.

The responses to "I will never be able to enjoy life again (my wife will never . . .)"* (see Appendix C, Item 13) indicates that 17 husbands (85 percent) and 18 wives (90 percent) disagreed with the statement. Only 3 husbands and 2 wives agreed with item 13.

Nineteen husbands and 20 wives disagreed either strongly or mildly with the statement "I might as well

*Husbands' response to the Coping Index.

give up because I can't make things better for myself (for my wife)"* (see Appendix C, Item 16). Only 1 husband disagreed mildly with this item. Of the total group of husbands (N = 20), 95 percent (19) disagred with item 16. Of the total group of wives (N = 20) 100 percent (20) disagreed with the same item. This data indicates that there is essentially no difference in the way husbands and wives responded in relation to item 16.

The final item relating to Capitulating in the instrument is "My future seems dark to me (my wife's future)"* (see Appendix C, Item 17). Seventeen husbands and seventeen wives disagreed with the statement. Three husbands and three wives agreed with the item. Of the total group of husbands (N = 20), 17 (85 percent) agreed, and of the total group of wives (N = 20), 17 (85 percent) agreed with the statement. Again this data indicates that there is essentially no difference in the way husbands and wives responded in relation to "the future seeming dark."

In summary, items 8, 13, 16, indicate that both husbands and wives were coping quite similarly (5 percent differences in each item). The degree of Capitulating was minimal in this group of 20 husbands and wives. In Item 11 there was a 10 percent difference

*Husbands' response to the Coping Index.

between how husbands and wives responded, the husbands capitulating less than the wives. In Item 17 there was no difference in how the husbands and wives responded to the statement.

Summary

In this section the descriptive findings of population Coping Styles for Hypothesis IV have been presented. Among the findings are those in the area of Vigilant Focusing Coping Style. Of a total group of husbands (N = 20) and wives (N = 20), 19 husbands and 18 wives indicated that they were actively seeking more information about cancer (see Appendix C, Item 1). Twelve of both husbands and wives indicated that things would be better if family and friends would talk openly with them about cancer (see Appendix C, Item 21). Eighty-five percent of both husbands and wives disagreed with Item 24 (see Appendix C), that of seeking professional counseling.

In the area of Minimization Coping Style significant differences between husbands and wives were identified. Of the total group of husbands (N = 20) and wives (N = 20), 14 (70 percent) husbands indicated that they were not trying to forget their wife's illness (Item 4, see Appendix C), while 10 (50 percent) wives indicated that they were trying to forget their illness.

Only in Item 10 (see Appendix C), reducing tension by overeating, overdrinking, or excess drug usage did husbands (19) and wives (2) respond similarly by disagreeing with the statement.

In the Tackling Coping Style findings, 16 of the husbands and 17 of the wives indicated that they can look forward to more good times that bad (see Appendix C, Item 18), and at the same time 15 (75 percent) husbands of a sample of twenty, and 18 (90 percent) wives (N = 20) responded that they look forward to the future (Item 18, see Appendix C).

In the area of Capitulating Coping Style, 17 of the husbands and 16 wives responded that the wife would not die soon of cancer (see Appendix C, Item 8). There was no difference between how the husbands and wives responded to the future seeming dark (see Appendix C, Item 17). In summary, the degree of overall Capitulating was minimal for both husbands and wives.

Reliability of the Instrument

The reliability of the instrument was measured by using the formula for coefficient Alpha as described in Chapter IV. The total scale measuring Coping Styles of husbands and wives was divided into five scales: Vigilant Focusing, Minimization, Tackling, Capitulating, and Coping Style (Total).

Prior to calculating the reliability coefficient the variance of the total scale and the variances between items in each scale were determined. Using the Cronbach (1970) formula for coefficient Alpha the reliability coefficient of the instrument was then computed. The reliability coefficient for the entire instrument, Coping Style (Total) was calculated at .62 showing a marked interrelationship between the items of the scale.

The reliability coefficients for each of the smaller scales are as follows: Vigilant Focusing (.57), Minimization (.41), Tackling (.68), and Capitulating (.82). Each of the four smaller scales had only six items while the entire scale had twenty-four items. The inter-item relationships of the smaller scales could have been increased by adding similar questions to the scales. However, in this study increasing the length of the instrument was not feasible. Therefore, the entire scale (instrument) of twenty-four items was found to have a marked, somewhat high internal consistency.

Summary of the Chapter

In Chapter V the data and analysis have been presented for the research hypotheses. An overview was presented describing the focus of the chapter. The descriptive findings of the population presented a discussion of age, education, income, occupation, years of marriage, number of children in the family, number of children still living at home, date of diagnosis of the women with cancer, type of cancer of the women, and type of treatment of the cancer. The data were presented for each of the four hypotheses. For Hypothesis I the differences in means between the Coping Styles of husbands and wives by computing the t-value was presented. Hypothesis I was not rejected. For Hypothesis II the differences in means between the Cognitive Coping Styles of husbands and wives by computing a t-value was presented. Hypothesis II was not rejected. For Hypothesis III the differences in means between the Behavioral Coping Styles of husbands and wives by computing a t-value was presented. Hypothesis III could not be rejected. The descriptive findings of population Coping Styles were presented for Hypothesis IV. The reliability of the instrument was presented using Coefficient Alpha.

In Chapter VI the summary, conclusions, and implications for future studies will be presented. The chapter will focus on the summary and interpretation of the findings, generalizing of the results, the implications for nursing, and the recommendations for future research.

CHAPTER VI

SUMMARY, IMPLICATIONS, AND RECOMMENDATIONS

Overview

The purpose of the study was to determine if there are similarities in coping styles of the primary dyad in the family, that of husband and wife, when the wife is terminally ill. Specifically the study identified the differences between the mean scores of Coping Style (Total) of husbands and wives, and the differences between the mean scores of Cognitive Coping Style of husbands and wives, and Behavioral Coping Style of husbands and wives.

Severe physical illness almost always represents a serious upset in an individual's equilibrium. The individual facing a severe illness may encounter the loss of key roles in life, changes in appearance or bodily functions, assaults on self-image, helplessness, and an unpredictable future. The illness may extend over a long period of time, presently the ill individual as well as all the family members with a complex set of new issues over which they may have had few experiences, and little resources available. Not only is the terminal illness viewed as a personal tragedy, but as an assault on the integrity of the family as well. Caplan (1964) maintains that the individuals experiencing a life crisis are more susceptible to external influences at that time than they are during periods of more stable functioning. This period of receptivity offers those in the nursing profession an opportunity to have a strong constructive impact on the lives of those in crisis.

It is essential for family members and affected individuals to cope with the terminal illness in order to recognize and achieve a new equilibrium. When a terminally ill individual and his/her spouse are using discrepant and incompatible coping styles, continued family functioning is impossible without some reorganization. An example of this is seen when a cancer patient is seeking information and emotional support, and his/her spouse is denying that there is anything wrong. In a review of the literature very little research was identified related to the coping styles of husbands and wives in times of crisis; although family coping was reported frequently. Therefore, the present study was initiated to identify the differences in coping styles of husbands and wives. Because the middle years are characteristic of the married couple alone constituting the nuclear family, and since a greater number of women who met the criteria were found to be in their middle years, the study was delimited to only women with a terminal illness and their husbands within the age range of 40-65.

The researcher was primarily interested in the differences in the expressed coping styles of the husband and wife when the wife was terminally ill. Four hypotheses were developed from the initial problem statement.

Because the intent of the study was to initially identify the coping styles of husbands and wives, Hypothesis I was developed as follows:

> I. There is no statistically significant difference between the expressed Coping Styles (Total) of the husband and wife when the wife is terminally ill.

The variables represented in Hypothesis I are Coping Styles (Total), Cognitive Coping Style, Behavioral Coping Style, Husband and Wife.

Hypotheses II and III evolved from Hypothesis I.

> II. There is no statistically significant difference between the expressed Cognitive Coping Style (Vigilant Focusing and Minimization) of the husband and wife when the wife is terminally ill.
>
> III. There is no statistically significant difference between the expressed Behavioral Coping Style (Tackling and Capitulating) of the husband and wife when the wife is terminally ill.

In Hypothesis II the variable Cognitive Coping Style was divided into subvariables Vigilant Focusing and Minimization. In Hypothesis III the variable Behavioral Coping Style was divided into subvariables Tackling and Capitulating. The variables Husband and Wife were also represented in both Hypotheses II and III.

Hypothesis IV was developed in order to describe the findings of the population Coping Styles under study.

> IV. The Coping Styles (Total) of husband and wife, when the wife is terminally ill, can be identified.

Coping Styles (Total), Husband and Wife, Cognitive Coping Style, and Behavioral Coping Style were the variables represented in Hypothesis IV.

The data presentation and analysis focused on the findings for each of the four hypotheses. Results of the study form a basis for further research by health care professionals, extend the knowledge base for nursing, as well as influence the clinical judgment and interventions of those in the nursing profession. In the following sections a summary of the findings, the problems encountered in the study, implications for nursing, and recommendations for future research are presented.

Summary of the Findings

This section describes the findings from the study. Each hypothesis is presented and discussed.

Hypothesis I

> There is no statistically significant difference between the expressed Coping Styles (Total) of the husband and wife when the wife is terminally ill.

The two components of Coping Styles are cognition and behavior (action). Therefore Cognitive Coping Style and Behavioral Coping Style together form an overall style of coping, or in this study, Coping Styles (Total). Because there is no statistical technique to apply to only two people in a sample (husband and wife), the total population (N = 40) of husbands and wives were analyzed for differences in coping styles by using the t-test. The t-test is particularly useful in analyzing the differences in means between two samples (less than 30). It was appropriate in this study to analyze the data using the t-test since 20 husbands and 20 wives were being studied.

The differences in means between Cognitive Coping Styles of husbands and wives, as indicated in Table 8, shows a t-value of -1.79 which is not significant at the .05 level. The same is true for the differences in means between Behavioral Coping Styles of husbands and wives. The t-value was calculated at .32, which is again not significant. Thus, using the Coping Styles (Total) means for husbands (43.45) and wives (46.05), a t-value of -1.31 indicated that there was no significant difference between Coping Styles (Total) of husbands and wives. The findings support the literature which indicates that husbands and wives do in fact cope similarly to life crises (Kaplan, 1973; Moos, 1977). This finding has particular significance to the nurse, since it is the nurse who may best interact with the husband and wife during this crisis, either in the hospital setting, or in the couple's home. By understanding the nature of the crisis as experienced by the husband and wife, and appreciating that there are characteristic patterns in which they cope, the nurse will be able to more effectively support and guide the marital dyad to acquire coping styles that will restore organized family functioning. The findings from the data obtained for Hypothesis I indicate that the nurse will be able to treat the marital dyad in the same way in regards to the wife being terminally ill.

Hypothesis II

> There is no statistically significant difference between the expressed Cognitive Coping Style (Vigilant Focusing and Minimization) of the husband and wife when the wife is terminally ill.

Cognitive Coping Style is characterized by an individual's response to illness, including perception, thought, and problem-solving activities. In this study Cognitive Coping Style was composed of two modes of cognitively dealing with a serious illness: Vigilant Focusing and Minimization.

The differences in means between Vigilant Focusing of husbands (13.35) and wives (14.30) as presented in Table 8, indicates a t-value of -1.07 which is not significant at the .05 level. However, the differences in means between the Coping Style Minimization of husbands (10.35) and wives (12.90) were significant. The t-value of -3.34 indicated that there was a difference between the husbands and wives on the Coping Style of Minimization. These findings demonstrate that in general the wives in this study (N = 20) tended to minimize their illness more than their husbands. The extent to which Minimization is used varies among individuals. Feder (1966) indicates that this coping style is common in the early phases of cancer victims. Eight of the total group of women (N = 20) in this study had been diagnosed as having cancer less than 12 months when the Coping Index was completed. Kübler-Ross (1965) suggests that the use of denial or some other form of Minimization for six to eighteen months is not uncommon. Provided that this is not the only coping style utilized, Minimization is not seen as ineffective, rather it is a means of rescuing and protecting the individual from being totally overwhelmed. This period is generally used for gathering other coping resources.

Using the Cognitive Coping Style (Total) means for husbands (23.70) and wives (27.20), a t-value of -1.79 indicated that there was no significant difference. Although the overall Cognitive Coping Style (Total) scores indicated no difference between the husbands and wives, it is more practical to analyze the differences related to specific coping styles. Implications related to the similarities and differences between husbands and wives on Vigilant Focusing and Minimization will be discussed further in a later section.

Hypothesis III

> There is no statistically significant difference between the expressed Behavioral Coping Style (Tackling and Capitulating) of the husband and wife when the wife is terminally ill.

Behavioral Coping Style is characterized by habitual modes of acting in response to illness. The emphasis is on predominant action tendencies of the individual, rather than on intellectual processes. In this study Behavioral Coping Style was composed of two modes of actively dealing with a serious illness: Tackling and Capitulating.

The differences in means between Tackling Coping Style of husbands (10.75) and wives (10.30), as presented in Table 9, indicates a t-value of .38 which is not significant at the .05 level of confidence. The difference between husbands and wives on this coping style was negligible. These findings indicate that both husbands and wives adopt an active attitude towards challenges and tasks posed by the illness to nearly the same degree. The tackling actions are aimed at prompt recovery, or at least compensation for a disability.

The differences in means between Capitulating Coping Style of husbands (9.00) and wives (8.55) shows a t-value of .44, again indicating no significant difference at the .05 level. These findings infer that the extent to which husbands "passively give in" to the illness is very similar to that of their terminally ill wives. Lipowski (1970) emphasizes that capitulating can be the most adaptive form of behavior during the acute stages of a serious illness. The similarities of this coping style between husband and wife may be due to the fact that the 13 wives had been diagnosed less than 18 months when the Coping Index was completed, and the seriousness of the illness had not fully impacted both the husbands and wives in this study.

Using the Behavioral Coping Style (Total) means for husbands (19.75) and wives (18.85), a t-value of .32 indicated that there was no significant difference. Further implications related to the similarities between the coping styles of Tackling and Capitulating will be presented in a later section.

Hypothesis IV

> The Coping Styles of husband and wife, when the wife is terminally ill, can be identified.

Vigilant focusing.--Nineteen husbands (95%) and eighteen wives (90%) indicated that they were actively seeking more information related to the cancer. This finding indicates that both husbands and wives were vigilant focusing nearly to the same degree in relation to seeking new information which would help them understand the circumstances better. Sixteen husbands (80%) and sixteen wives (80%) related that they were confronting the doctor to answer questions related to the cancer. By obtaining adequate information about the illness, both husbands and wives may have relieved anxiety caused by uncertainty and misconceptions. To the statement "things would be better if my family and friends would talk openly with me about cancer," twelve husbands (60%) and twelve wives (60%) indicated that things would be better. Once again the findings relate similarities in vigilant focusing of husbands and wives. By talking with others, activities directed toward reestablishing an equilibrium was initiated. Fifteen husbands (75%) and thirteen wives (65%) indicated that things would be better if the doctor would talk to them more about the illness. Only seven (35%) husbands and six wives (30%) related that things would be better if they knew where to get financial help. Perhaps financial help was not needed by these people since the mean annual income for this population was between \$20,000-\$24,000 or perhaps the wording of the statement was not specific enough. In any event, husbands and wives vigilantly focused to the same extent. Seventeen (85%) of both husbands and wives indicated that professional counseling was not necessary. This finding inferred that although both husbands and wives were not using vigilant focusing, they were coping similarly. Again, the wording of the item may have been inadequate, and thus was not an accurate indication of vigilant focusing.

Minimization.--While nineteen (95%) husbands indicated that they did not laugh off everyone's concern about their wife's illness, only thirteen (65%) of the wives felt the same way. This indicates that the wife was minimizing to a greater extent than her husband, which actually is not surprising. Minimization may enable isolation or dissociation of one's emotions when dealing with the threat of bodily integrity, where it is not necessary for the husband since he is unaffected physically by the illness. Six husbands (30%) and ten wives (50%) indicated that they try to forget about the cancer. This finding suggests that half of the women did try to forget they have cancer, which is not uncommon during early phases of the cancer. In this study, eight or 40% of the women had been diagnosed with a terminal illness within the last year. Eleven wives (55%) related that they spend time at little tasks to keep them from thinking about their illness, while only eight husbands (40%) related the same thing. Again, this indicates that the wives in this study tended to minimize more than their husbands. Six (30%) of the wives and two (10%) of the husbands related that there is something good about having cancer, which was an unexpected response. Perhaps religious convictions influenced these people's responses, or perhaps denial was so strong that the individuals were continuing to suppress anger, and thus were ineffectively dealing with the situation. Perhaps these people's responses were also influenced by the fact that the terminal illness was bringing a closure to the life of the family unit. The realization of the husband and wife that their relationship would soon end may have had an impact on their response. Twenty wives (100%) and nineteen husbands (95%) indicated that they did not reduce tension related to the cancer by overeating, overdrinking or excess drug usage. Nearly a nonexistent degree of minimization by both husbands and wives was indicated in the responses to this particular item. In the final item addressing minimization eleven husbands and twelve wives related that the wives would soon be just as good as before. Again this finding suggests that the wives and husbands coped similarly in this item.

Tackling.--All of the husbands (20) and nineteen of the wives related that they either encouraged their wife to follow the doctor's orders, or follow the doctor's orders, respectively. This indicates a negligible difference in the use of the coping style Tackling. However, eighteen (90%) of the husbands and only thirteen of the wives (65%) related that they talked with others to relieve the stress. Perhaps this finding reinforces the findings related to minimization, where the wives used denial more frequently than their husbands, therefore indicating the need for talking with others is less. Husbands (16) and wives (17) were again similar in their use of tackling when they indicated that they work out good alternatives to their plans affected by their cancer. This finding shows an active attitude towards challenges and tasks posed by the illness on the part of both husbands and wives. Eighteen wives (90%) and fifteen (75%) husbands indicated that they look forward to the future. Perhaps this difference in tackling is again due to the fact of the wives' tendency to minimize their illness. The husbands may have fully understood the consequences of the illness and engaged in preparatory grief, while the wives continued to deny the severity of the illness. In the item, "I will fight the illness any way I can," fourteen (70%) husbands and twelve (60%) wives said that they would. The Tackling actions of the husbands were aimed at prompt recovery or compensation, while the wives were less willing to fight the illness. Perhaps the wives' unwillingness to do this is again due to the degree of minimization used. The final item, "I can look forward to more good times than bad," indicated that the wives and husbands coped similarly. Overall these findings indicate that there was little difference in the coping style Tackling between husbands and wives.

<u>Capitulating</u>.--Seventeen (85%) husbands indicated that they did not think their wives would die soon of cancer. Sixteen (80%) wives indicated that they did not think they would die soon of cancer. These

findings relate that the majority of husbands and wives were not demonstrating a passive manner to the serious illness. Both husbands (17) and wives (15) related that they did not hate to attend social gatherings due to the illness. However, more women than men were less willing to attend social events. Perhaps this had to do with alteration in body image, or the unwillingness to discuss the illness with friends, as was suggested with the responses toward the Tackling items. Fifteen (75%) of the husbands and seventeen (85%) of the wives felt that the wife would get well, indicating that the wives were being less passive and more hopeful than their husbands. Seventeen (85%) husbands and eighteen (90%) wives felt that the wife would be able to enjoy life again. This finding suggests that both husbands and wives were taking an active approach to the illness, and not "giving in" to the situation. Nineteen husbands (95%) and all of the wives (20) indicated that they would not give up because they couldn't make things better for their wives or themselves. Again, this pattern of coping infers that capitulating to a great extent is not a part of the married couple's repetoire. The final statement of the future of the wife seeming dark found that seventeen (85%) of both husbands and wives disagreed with the item. This finding indicated that the couples were demonstrating initiative toward fighting the illness rather than using a passive approach.

In summary, the findings from the four hypotheses of this study suggest that husbands and wives do in fact cope similarly to the impending death of the wife in each of the coping styles with the exception of minimization.

Problems Encountered in the Study

In this section the problems encountered in the study are presented. The most significant problem was that the sample size was small (N = 20 couples) and the population was drawn from the same clinical setting. Because of these two factors, generalizations can only be made to the population under study. If it had been feasible to randomly select the population, and at the same time increase the sample size (N) greater generalizations could have been made. Had the sample size been increased, the differences in means between the coping styles of husbands and wives would have probably changed, decreasing the standard error of measurement.

Another problem was related to the instrument used in the study. Since no method was available, the Coping Index was not tested for content validity. Therefore, the differences in means between the minimization coping style of husbands and wives could have resulted from the inaccuracy of the scale measuring minimization.

An additional problem was the fact that the researcher who made the initial contact with each of the twenty couples also assisted the participants in completing the instrument. Replication of the study on a larger scale, using at least two researchers, should eliminate any biasing effects. From the findings in this study implications for nursing can be generated, and are presented in the next section.

Implications for Nursing

Specific implications in the area of Vigilant Focusing are that both husbands and wives were actively seeking more information related to the cancer, confronting the doctor to answer specific illness-related questions, and talking openly to family and friends about the illness. The nurse must recognize these cognitively-based actions as a process of gathering new knowledge to understand the illness better. Both husband and wife may also use vigilant focusing to ensure that other family members will not be affected by cancer. During the period of recognizing the meaning of cancer (intellectualizing) the nurse can attempt to foster security of the family members by encouraging the use of the coping style vigilant focusing. This coping style will enhance the family's integrity and identity under the stressful event of cancer.

The husbands and wives in this study did not indicate that financial assistance or professional counseling was necessary, nor did they seek out information regarding these services. The major implication in this case is that the nurse appropriately assess the couples to ensure that they are aware of the community and professional resources available to them. The availability and accessibility of resources is paramount to seeking and utilizing them. The nurse has a vital role in providing information to the marital dyad or by arranging a referral regarding these services. In this way the use of the coping style vigilant focusing is reinforced and encouraged by the professional nurse.

A specific finding in the area of minimization is that both husbands and wives in this study did not reduce tension related to the cancer by overeating, overdrinking, or excess drug usage. This implies that the coping style minimization was not in effect, at least in relation to excessive intake of any substance. The nurse's role in this respect is to reinforce the couples in their attempt to maintain some sense of equilibrium in the home setting. Had the couples in this study indicated that they did indulge in excessive intake of substances to deny or rationalize the illness, professional counseling would be in order. The nurse must be able to assess this problem initially, and refer appropriately to the most suitable professional available. The nurse herself/himself is also capable of counseling in this instance.

The majority of husbands indicated that they did not laugh off everyone's concerns about their wife's illness, while a much lesser percentage of the women felt the same way. This indicates that the wives in this study minimized their illness to a greater extent than the husbands. The nurse must recognize that the wives' use of minimization may enable them to isolate or dissociate emotions when dealing with the threat to bodily integrity. The use of minimization in the early stages is very common, and essentially healthy. Continued use of this coping style, however, could be psychologically disabling in terms of accepting the serious illness. The nurse's role is to recognize the importance of minimization, but also to distinguish its appropriateness to the current situation, and to assist the marital dyad in acquiring an alternative coping style should minimization become ineffective for husband and/or wife.

Half of the women in this study indicated that they try to forget that they have cancer, while a much smaller percentage of husbands felt the same way. When the initial diagnosis of a terminal illness is revealed, a high degree of non-productive behavior may be evident. Kübler-Ross (1969) maintains that this is a time which allows the ill individual and other family members to collect themselves and mobilize other resources. The goal of nursing intervention at this time of impact is to foster hope. The significance of the use of minimization is necessary for the nurse to understand, especially when the diagnosis has recently been revealed.

Over half the women in the study related that they spend time at little tasks to keep them from thinking about their illness, while less than half of the husbands felt the same way. This is consistent with Feder (1966) who suggests that because the ill person minimizes in this way early in the disease process, the entire family needs assistance in various activities. The nurse can be of assistance by helping the family to accept hope, and to help the ill person to make plans by decision-making. In this way the nurse can guide the cancer patient to realistically perceive the illness, rather than attempting to avoid or deny it.

The majority of husbands and wives felt that there was nothing good about having cancer, which was an expected response. Perhaps those few who did relate that there was something good about having cancer were influenced by religious convictions, or the use of minimization was so strong that they were inclined to respond in this manner. A role of the nurse in this situation would be to assess further the religious behaviors of other social influences which would cause the individual to respond that there was something good about having cancer.

Over half of both husbands and wives indicated that the wives would soon be just as good as before. This has implications for nursing such that the marital dyad needs to be aware of the degree to which minimization is being used. Again, the element of hope cannot be disregarded, and the nurse must be especially careful not to dispel the couple's faith in a cure. However, continued reliance on minimization as the essential mode of coping will cause the couple and the family to disintegrate. By helping the couple to realistically view the seriousness of the illness and to plan goals for continued family functioning, the nurse will effectively direct the energies needed to deal with the crisis.

Specific implications in the area of tackling are that all of the husbands and wives in this study (with the exception of one wife) related that they either encourage their wife to follow the doctor's orders, or follow the doctor's orders, respectively. The majority of the husbands and wives also indicated that they work out good alternatives to their plans affected by cancer, and that both looked forward to more good times than bad. The nurse should recognize that these action tendencies are aimed at prompt recovery or compensation for a loss. Tackling should be encouraged by the nurse since it is a rational behavior, and directed toward current demands of the illness. By the nurse's continual support, the marital dyad can actively take part in the challenges and tasks posed by the illness. The marital dyad's cohesion in working together should be strengthened by the nurse's encouragement and support to regain equilibrium following the initial impact of the illness.

The majority of the husbands related that they talk with others to relieve distress, while only a few over half of the wives felt the same way. Perhaps the nurse can help the wives to realize the importance of this tackling strategy in order to reduce the amount of minimization. When the individual denies the illness, talking with others to relieve distress is of little importance. By working with the husbands in this case and helping them to understand their wives' perception of her cancer, the nurse may be able to influence the wife to use tackling more frequently.

More of the wives than the husbands indicated that they looked forward to the future. The nurse must consider if "the future" means death to the wife or husband. If so, then the individual may be engaging in preparatory grief, and thus realisitically viewing the situation. On the other hand looking forward to the future may indicate a tendency to minimize the illness. Therefore, the wives in this study could have been minimizing (optimistic about their welfare), while their husbands were tackling the situation and engaging in preparatory grief. This set of circumstances causes an incompatible arrangement which may totally disrupt functioning of the family unit. The nurse's intervention must focus on fostering cooperation and reorganization of both husband and wife.

The majority of husbands, and over half of the wives related that they would fight the illness any way they could. Again the element of hope cannot be denied. The nurse should foster hope and yield encouragement as deemed appropriate. Irrational behavior, such as using a lost bodily part as if it were intact, should be recognized as pathological by the nurse, and assisted to seek additional professional help immediately.

Implications in the area of Capitulating are that the majority of husbands and wives did not think that the wife would die soon of cancer, did not think the wife's future seemed dark, did not want to give up because they couldn't make things better, and felt that the wife would soon be able to enjoy life again. This implies that the coping style capitulating was not in effect in these four areas. The nurse must recognize these behaviors as healthy, and appropriately encourage the marital dyad to be hopeful. These actions indicate that the marital dyads were attempting to maintain a degree of equilibrium in the home, and should be supported in their endeavors.

More wives than husbands were less willing to attend social gatherings due to illness. Perhaps the nurse could assess further the reasons for this, and guide and direct the couple toward understanding the social implications of cancer. Because women are generally more self-conscious about their appearance than men are, alteration in body image due to surgery, radiation or chemotherapy may hinder the desire to socialize. The nurse's understanding of this situation, and her ability to discuss this with the ill women's husbands, will help the marital dyad to regain some cohesion that was lost due to discrepancies in coping style.

Finally more wives than husbands felt that they would get well again, indicating that the wives were being less passive and more hopeful than their husbands.

The nurse's role in this situation is to allow the husbands some degree of withdrawal or "passive giving in" since this can be the most adaptive form of behavior during the early stages of illness. However, the nurse's expertise in recognizing the habitual mode of using capitulating to deal with the illness is paramount in assisting the individual in choosing an alternative coping style.

The goal of nursing when working with an individual, a dyad or a family is to seek the highest level of functioning, and to assist them in maintaining this stability. How the nurse accomplishes this depends on acceptance by the family, motivation of its members to make changes, and appropriate identification of the discrepancies in coping. Hopefully, this section has been informative in these areas.

Since the instrument used in this study had a marked, somewhat high reliability coefficient, the use of this Coping Index as a screening tool could be very valuable. By increasing the number of items in the scale, or by deleting the items with a low inter-item relationship, especially those in the minimization scale, the internal consistency of the instrument would be increased. These changes would increase the reliability of the instrument, and thus yield informative data about the marital dyad and their coping styles.

Not only does this instrument have implications for those with cancer, but other chronic illnesses as well.

Relationships of Findings to Conceptual Framework

The findings of this study are consistent with the conceptual framework presented in Chapter II. The three general determinants of coping style predominant in the literature were initially assessed by the researcher. Intrapersonal factors, illness-related factors, and environmental factors were determined from each of the twenty participating couples via the Basic Data Profile Sheet. The intrapersonal factors included the following characteristics: age, educational level, religion, and sex. Illness-related factors included the type and location of the illness, the date of diagnosis, the type of treatment for the cancer, and the degree of change in daily routine since the diagnosis of cancer. The third determinant of coping, that of environment, included the following characteristics: race, occupation, mean family income, years of marriage, number of children, and number of children still living at home.

Intrapersonal factors, illness-related factors, and environmental factors all contribute to the subjective meaning that the illness has for an individual, as suggested in the conceptual model. Cognitive appraisal of one's illness involves the complex nature of all these factors, and is essential for the nurse to assess prior to any type of intervention of the marital dyad.

Adaptive tasks are encountered by the marital dyad through the cognitive appraisal of the illness. The seven tasks presented in Chapter II are generally characteristic of every illness. However, the importance of each task varies depending on the three determinants of coping: the nature of the illness, personality factors, and environmental circumstances. Although outlined in the operational model in Chapter II, the adaptive tasks encountered by the twenty participating married couples were not directly assessed in this study. Therefore, the adaptive tasks having an integral role in the development of coping styles was of theoretical nature in this study. However, the relevance of this type of informative data in further studies cannot be underestimated. Through cognitive appraisal of the illness, the individual employs a variety of coping styles to deal with the adaptive tasks. The nurse has an obligation to appropriately assess the tasks posed by the illness in order to fully understand the coping styles of each husband and wife.

The coping styles of the participants in this study were determined by the completion of the Coping Index. It is assumed that the husbands' and wives' coping styles were influenced by the three determinants of coping, as well as the adaptive tasks posed by the illness. Four coping styles were assessed: Vigilant Focusing, Minimization, Tackling, and Capitulating. Discrepencies between coping styles of husbands and wives were then determined. The findings in this study suggest that husbands and wives do in fact cope similarly when the wife is terminally ill, with the exception of Minimization. The findings imply that the wives tended to minimize or deny their illness and its consequences more so than the husbands. This indicates that the marital dyad may encounter disruption in the family network which could eventually lead to family unit disintegration. The final phase in the conceptual model for this study is the role of nursing intervention in terms of facilitating effective coping between husband and wife. Again, this phase of the model was theoretical and was not tested as to the effectiveness of nursing intervention. However, strategies for assisting the marital dyad to cope more effectively were presented in both Chapters II and VI, since actual intervention was not an intent of this study. The nursing intervention phase was integrated into the model to imply that nursing specifically has a role in facilitating effective coping in the marital dyad. In future research studies this phase could appropriate be put into effect and tested. In the next section recommendations for future research are presented.

Recommendations for Future Research

1. Replication of the study with a larger sample, perhaps randomly selected, is needed to identify the coping styles of husbands and wives when the wife is terminally ill. The findings of such studies could then be compared so that generalizations can begin to be made.

2. In order to decrease the possibility of a biasing effect of one researcher, at least two researchers to conduct the study is recommended.

3. Future studies would need to reduce the number of items in the instrument so that the items causing low inter-item reliability are deleted. This measure would not only increase the internal consistency of the instrument, but would also reduce the length of the instrument and the time to complete it.

4. A similar study should be conducted using the same instrument as well as a standardized measure of Coping Styles (if available). The validity coefficient of the instrument could then be computed.

5. A similar study should be conducted with terminally ill husbands and their wives. The findings of such studies could then be compared so that generalizations can begin to be made.

6. Experimental studies are needed to determine the most effective way to handle coping discrepancies in marital dyads. Such studies should be based on the findings from the present study as well as other studies, since Coping Style discrepancies need to be identified before professional assistance can be offered.

7. Studies are needed to assess and consider extraneous variables as determinants to Coping Style not identified in the present study.

8. A similar study should be conducted over a period of time, so that coping styles of husbands and wives could be assessed during each phase of the disease process.

9. A study should be conducted which would assess the coping style of the woman who is single, or widowed, and is facing a terminal illness. The results of this study would indicate the role of the nurse in assisting the woman alone through this life crisis.

APPENDICES

APPENDIX A

LETTER TO STUDY PARTICIPANTS AND CONSENT FORM

APPENDIX A

LETTER TO STUDY PARTICIPANTS

September 8, 1978

Dear ______________________,

The attached consent form and data profile sheet is concerned with the research study on coping styles in women experiencing cancer, and their husbands. This study is being conducted by myself as part of the requirements for a master's degree in nursing. The study is concerned specifically with determining if the coping styles of the husband and wife are similar in regard to the diagnosis of cancer.

Please complete the enclosed forms (time involved 10 minutes) and return them in the stamped envelope provided at your earliest convenience. Both of you will also be asked to complete a questionnaire (time involved 20 minutes) at an appointment arranged at your convenience. I am particularly interested in obtaining your responses because of the significant contribution you can make toward future nursing interactions to those with cancer and their spouses. The results obtained will be used in assisting nurses to determine coping styles of both husband and wife and means for helping them through this family crisis. It will be appreciated if you will complete these enclosed forms and return them to me by September 18. Other phases of this research cannot be carried out until all consent forms and profile sheets are collected.

I will be pleased to send to you a summary of the results of the study following its completion if you desire. Please be assured that your name will never be associated with the data and your identity and responses will remain confidential. Thank you for your time and cooperation.

Sincerely,

Carol Ann Dwyer, R.N.
Graduate Student, Family
Nurse Clinician Program
Home Phone (517) 1-783-4254

ENC/TWD

APPENDIX A

CONSENT FORM

SUBJECT'S STATEMENT

I voluntarily consent to participate in this research study. I have had an opportunity to ask questions and clarify details, and I may change my mind before the study is completed if I choose to.

Signature of Female Subject	Date
Husband's Signature	Date

APPENDIX B

BASIC DATA PROFILE

APPENDIX B

BASIC DATA PROFILE

Instructions: Please complete this data profile sheet at your earliest convenience and return in the pre-addressed stamped envelope enclosed. You are asked either to circle, check, or list your response to the statements. This information will be used by the researcher to determine common characteristics in the participants of the study. Your name will not be associated with the data, and your identity and all responses will remain confidential.

Age:_________________________

Patient Identification Number

Sex (circle): Male_____ Female_____

Religion (check one): Protestant ____ Other ____ (specify)
Catholic ____
Jewish ____

Race (check one): Caucasian ____ Oriental ____
Afro American ____ Other ____ (specify)
Mexican American ____

Occupation (check one): Housewife ____
Clerical ____
Professional ____
Self-employed ____
Skilled worker ____
Retired ____
Other (specify) ____

Mean Family Income (check one): 1,000-4,999 ____
5,000-9,999 ____
10,000-14,999 ____
15,000-19,999 ____
20,000-24,999 ____
25,000 and over____

Date of Diagnosis: Month ____/Year____ Not applicable ____

Number of Children:_________

Ages of Children (please list):_________________________

Number of Children Living at Home:______________________

Number of Years of Marriage:_____________

Highest Level of Education Attained (check one):

Grade 1-8 ____
Not completed high school ____
High school completed ____
College ____
Advanced degree (specify)_______________________

What is the treatment for your cancer (check as many that apply):

Chemotherapy ____
X-Ray Therapy ____
Surgery ____
Other (specify)____
Not applicable ____

Check that which applies to <u>you</u>:

____My daily routine is just like it was before the diagnosis of cancer.

____My daily routine has changed very little since the diagnosis of cancer.

____My daily routine is different since the diagnosis of cancer.

____My daily routine has completely changed since the diagnosis of cancer.

Describe any previous personal experiences with cancer.

APPENDIX C

THE INSTRUMENT WITH KEY FOR SCORING

APPENDIX C

THE INSTRUMENT WITH KEY FOR SCORING

HUSBAND'S QUESTIONNAIRE

The following is a list of statements regarding how one copes with the diagnosis of cancer. Your responses to these statements will contribute significantly toward future nursing interactions with those with cancer, and their spouses. If you strongly agree with the statement as it stands, please check the box strongly agree; if you mildly agree with the statement as it stands, please check the box mildly agree, etc.

Since this is a survey of feelings, it is desired that you indicate your own personal feelings regarding these statements, regardless of what you think other people want you to say. There are no right or wrong answers to these statements.

	Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree
1. I try to seek more information about my wife's cancer. (positive)	1	2	3	4
2. I talk with others to relieve distress. (negative)	1	2	3	4
3. I laugh off everyone's concern about my wife's health. (negative)	4	3	2	1
4. I try to forget my wife has cancer. (negative)	4	3	2	1

	Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree
5. I spend time at little tasks to keep me from thinking about my wife's illness. (negative)	4	3	2	1
6. I encourage my wife to follow the doctor's orders. (positive)	1	2	3	4
7. There is something good about my wife having cancer. (negative)	4	3	2	1
8. My wife will die soon of cancer. (negative)	4	3	2	1
9. I work out good alternatives to some of my plans affected by my wife's cancer. (positive)	1	2	3	4
10. I reduce tension I have by overeating, over-drinking, and/or excess drug use. (negative)	4	3	2	1
11. I hate to go into public or to attend social gatherings because of my wife's illness. (negative)	4	3	2	1
12. My wife will never get well. (negative)	4	3	2	1
13. My wife will never be able to enjoy life again. (negative)	4	3	2	1

	Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree
14. My wife will soon be just as good as before. (negative)	4	3	2	1
15. I confront doctor to answer my questions concerning my wife's illness. (positive)	1	2	3	4
16. I might as well give up because I can't make things better for my wife. (negative)	4	3	2	1
17. My wife's future seems dark to me. (negative)	4	3	2	1
18. I look forward to the future. (positive)	1	2	3	4
19. I will fight my wife's illness any way I can. (positive)	1	2	3	4
20. I can look forward to more good times than bad with my wife. (positive)	1	2	3	4
21. Things would be a lot better if my family and friends would talk openly with me about my wife's cancer. (positive)	1	2	3	4
22. Things would be a lot better if the doctor would talk more with me about my wife's cancer. (positive)	1	2	3	4

	Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree
23. Things would be a lot better if I knew where I could get financial help. (positive)	1	2	3	4
24. My wife and I should get professional counseling. (positive)	1	2	3	4

WIFE'S QUESTIONNAIRE

The following is a list of statements regarding how one copes with the diagnosis of cancer. Your responses to these statements will contribute significantly toward future nursing interactions with those with cancer, and their spouses. If you strongly agree with the statement as it stands, please check the box strongly agree, if you mildly agree with the statement as it stands, please check the box mildly agree, etc.

Since this is a survey of <u>feelings</u>, it is desired that you indicate your own personal feelings regarding these statements, regardless of what you think other people want you to say. There are no right or wrong answers to these statements.

	Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree
1. I try to seek more information about my cancer. (positive)	1	2	3	4
2. I talk with others to relieve distress. (positive)	1	2	3	4
3. I laugh off everyone's concern about my heatlh. (negative)	4	3	2	1
4. I try to forget I have cancer. (negative)	4	3	2	1
5. I spend time at little tasks to keep me from thinking about my illness. (negative)	4	3	2	1
6. I follow my doctor's orders. (positive)	1	2	3	4
7. There is something good about having cancer. (negative)	4	3	2	1

	Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree
8. I will die soon of cancer. (negative)	4	3	2	1
9. I work out good alternatives to some of my plans affected by cancer. (positive)	1	2	3	4
10. I reduce tension I have by overeating, overdrinking, and/or excess drug usage (negative)	4	3	2	1
11. I hate to go out into public or attend social gatherings because of my illness. (negative)	4	3	2	1
12. I will never get well. (negative)	4	3	2	1
13. I will never be able to enjoy life again. (negative)	4	3	2	1
14. I will soon be just as good as before. (negative)	4	3	2	1
15. I confront doctor to answer my questions about my illness. (positive)	1	2	3	4
16. I might as well give up because I can't make things better for myself. (negative)	4	3	2	1
17. My future seems dark to me. (negative)	4	3	2	1

	Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree
18. I look forward to the future. (positive)	1	2	3	4
19. I will fight my illness any way I can. (positive)	1	2	3	4
20. I can look forward to more good times than bad with my husband. (positive)	1	2	3	4
21. Things would be better if my family and friends would talk openly with me about my cancer. (positive)	1	2	3	4
22. Things would be better if my doctor would talk with me more about my illness. (positive)	1	2	3	4
23. Things would be a lot better if I knew where I could get financial help. (positive)	1	2	3	4
24. My husband and I should get professional counselling. (positive)	1	2	3	4

APPENDIX D

HUMAN RIGHTS PROTECTION

APPENDIX D

HUMAN RIGHTS PROTECTION

Potential Risks to the Sample:

There are no physical risks to those involved in this study. However, during the completion of the Coping Index, there is a potential for the subjects to become overwhelmed emotionally due to the focus of some of the items relating to death. Prior preparation to ensure the least amount of emotional upset is provided by:

1. Providing both verbal and nonverbal support to the subjects while completing the Coping Index.
2. Providing the freedom to refuse to participate in the study, and assuring that this refusal would not alter the quality of health care in the oncology clinic.
3. Providing information of where to contact the researcher should any questions or concerns arise after completing the Coping Index.

Consent Procedures: (See Appendix A)

Participation in the study is voluntary. Verbal consent via the telephone is initially obtained by the researcher. The subjects will also sign a consent form indicating that they are willing participants which will be returned to the researcher by the mail. The signed consent form will allow the participants to make the decision to participate in the study without any pressure, or feeling obligated to comply.

Protecting Respondents:

The identity and responses of all subjects remains confidential. The subjects' names will never be discussed nor displayed with the data. Each couple is assigned a number (i.e. 01, 02, 03, etc.) to maintain anonymity, and this number will be used on the Basic Data Profile Sheets and the Coping Index.

The participants are further protected by (1) providing written consent, and (2) by providing data in aggregate rather than in individual form.

Potential Benefits to Participants:

The greatest benefit of the study is to the group of husbands and wives as a whole, since this study provides background information to the coping styles utilized by husbands and their terminally ill wives.

APPENDIX E

THE PRE-PILOT TEST

APPENDIX E

THE PRE-PILOT TEST

HUSBAND'S QUESTIONNAIRE

The following is a list of statements regarding how one copes with the diagnosis of cancer. Your responses to these statements will contribute significantly toward future nursing interactions with those with cancer, and their spouses. If you agree with the statement as it stands, please check the box yes; if you disagree with the statement as it stands, please check the box no.

Since this is a survey of feelings, it is desired that you indicate your own personal feelings regarding these statements, regardless of what you think other people want you to say. There are no right or wrong answers to these statements.

	YES	NO
1. I try to seek more information about my wife's cancer.	___	___
2. I confront the doctor to answer my questions concerning my wife's illness.	___	___
3. Things would be alot better if my family and friends would talk openly about my wife's cancer.	___	___
4. Things would be alot better if the doctor would talk more with me about my wife's illness and treatment.	___	___
5. Things would be alot better if I knew where I could get financial help.	___	___

	YES	NO
6. My wife and I should get professional counseling.	___	___
7. I talk with others to relieve distress.	___	___
8. I encourage my wife to follow the doctor's orders.	___	___
9. I work out good alternatives to some of my plans affected by my wife's cancer.	___	___
10. I look forward to the future.	___	___
11. I will fight my wife's illness any way I can.	___	___
12. I can look forward to more good times than bad with my wife.	___	___
13. My past experiences have prepared me well for the future.	___	___
14. When I make plans, I am almost certain to make them work.	___	___
15. I expect to get more of the good things in life than the average person even though my wife has cancer.	___	___
16. I do not laugh off everyone's concern about my wife's health.	___	___
17. I do not try to forget my wife had cancer.	___	___
18. I do not spend time at little tasks to keep me from thinking about my wife's illness.	___	___
19. There is nothing good about my wife having cancer.	___	___
20. I do not reduce tension I have by overeating, overdrinking, and/or excess drug usage.	___	___

	YES	NO
21. My wife will soon be just as good as before.	___	___
22. My wife will not die soon of cancer.	___	___
23. I do not hate to go out into public or attend social gatherings because of my wife's illness.	___	___
24. My wife will soon get well.	___	___
25. My wife will soon be able to enjoy life again.	___	___
26. I might as well give up because I can't make things better for my wife.	___	___
27. My wife's future does not seem dark to me.	___	___
28. My wife's treatment plan is totally effective.	___	___
29. My wife just doesn't get the breaks, and there is no reason to believe she will in the future.	___	___
30. My family hates my wife for being sick.	___	___

WIFE'S QUESTIONNAIRE

The following is a list of statements regarding how one copes with the diagnosis of cancer. Your responses to these statements will contribute significantly toward future nursing interactions with those with cancer, and their spouses. If you agree with the statement as it stands, please check the box yes; if you disagree with the statement as it stands, please check the box no.

Since this is a survey of <u>feelings</u>, it is desired that you indicate your own <u>personal</u> feelings regarding these statements, regardless of what you think other people want you to say. There are no right or wrong answers to these statements.

	YES	NO
1. I try to seek more information about my cancer.	___	___
2. I confront the doctor to answer my questions concerning my illness.	___	___
3. Things would be alot better if my family and friends would talk openly with me about my cancer.	___	___
4. Things would be alot better if the doctor would talk more with me about my illness and treatment.	___	___
5. Things would be alot better if I knew where I could get financial help.	___	___
6. My husband and I should get professional counseling.	___	___
7. I talk with others to relieve distress.	___	___
8. I follow my doctor's orders.	___	___
9. I work out good alternatives to some of my plans affected by cancer.	___	___

	YES	NO
10. I look forward to the future.	___	___
11. I will fight my illness any way I can.	___	___
12. I can look forward to more good times than bad with my husband.	___	___
13. My past experiences have prepared me well for the future.	___	___
14. When I make plans, I am almost certain to make them work.	___	___
15. I expect to get more of the good things in life than the average person even though I have cancer.	___	___
16. I do not laugh off everyone's concern about my health.	___	___
17. I do not try to forget I have cancer.	___	___
18. I do not spend time at little tasks to keep me from thinking about my illness.	___	___
19. There is nothing good about having cancer.	___	___
20. I do not reduce tension I have by overeating, overdrinking, and/or excess drug usage.	___	___
21. I will soon be just as good as before.	___	___
22. I will not die soon of cancer.	___	___
23. I do not hate to go out into public or attend social gatherings because of my illness.	___	___
24. I will soon get well.	___	___
25. I will soon be able to enjoy life again.	___	___

	YES	NO
26. I might as well give up because I can't make things better for myself.		
27. My future does not seem dark to me.		
28. My treatment plan is totally effective.		
29. I just don't get the breaks, and there is no reason to believe I will in the future.		
30. My family hates me because I am sick.		

APPENDIX F

THE PILOT TEST

APPENDIX F

THE PILOT TEST

HUSBAND'S QUESTIONNAIRE

The following is a list of statements regarding how one copes with the diagnosis of cancer. Your responses to these statements will contribute significantly toward future nursing interactions with those with cancer, and their spouses. If you strongly agree with the statement as it stands, please check the box strongly agree; if you mildly agree with the statement as it stands, please check the box mildly agree, etc.

Since this is a survey of <u>feelings</u>, it is desired that you indicate your own personal feelings regarding these statements, regardless of what you think other people want you to say. There are no right or wrong answers to these statements.

	Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree
1. I try to seek more information about my wife's cancer.	____	____	____	____
2. My wife's cancer will not spread.	____	____	____	____
3. Things would be alot better if my family and friends would talk openly with me about my wife's cancer.	____	____	____	____
4. Things would be alot better if the doctor would talk more with me about my wife's illness and treatment.	____	____	____	____

	Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree
5. Things would be alot better if I knew where I could get financial help.	____	____	____	____
6. My wife and I should get professional counseling.	____	____	____	____
7. I talk with others to relieve distress.	____	____	____	____
8. I encourage my wife to follow the doctor's orders.	____	____	____	____
9. I work out good alternatives to some of my plans affected by my wife's cancer.	____	____	____	____
10. I look forward to the future.	____	____	____	____
11. My past experiences have prepared me well for the future.	____	____	____	____
12. I can look forward to more good times than bad with my wife.	____	____	____	____
13. My wife will soon be just as good as before.	____	____	____	____
14. I do not laugh off everyone's concern about my wife's health.	____	____	____	____
15. I do not try to forget my wife has cancer.	____	____	____	____

	Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree
16. I do not spend time at little tasks to keep me from thinking about my wife's illness.	____	____	____	____
17. There is nothing good about my wife having cancer.	____	____	____	____
18. I do not reduce tension I have by overeating, overdrinking and/or excess drug usage.	____	____	____	____
19. I do not hate to go out in public or attend social gatherings because of my wife's illness.	____	____	____	____
20. My wife will soon get well.	____	____	____	____
21. My wife will soon be able to enjoy life again.	____	____	____	____
22. My wife will not die soon of cancer.	____	____	____	____
23. I will not give up because I can make things better for my wife.	____	____	____	____
24. My wife's future does not seem dark to me.	____	____	____	____

WIFE'S QUESTIONNAIRE

The following is a list of statements regarding how one copes with the diagnosis of cancer. Your responses to these statements will contribute significantly toward future nursing interactions with those with cancer, and their spouses. If you strongly agree with the statement as it stands, please check the box strongly agree; if you mildly agree with the statement as it stands, please check the box mildly agree, etc.

Since this is a survey of <u>feelings</u>, it is desired that you indicate your own personal feelings regarding these statements, regardless of what you think other people want you to say. There are no right or wrong answers to these statements.

	Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree
1. I try to seek more information about my cancer.	____	____	____	____
2. My cancer will not spread.	____	____	____	____
3. Things would be alot better if my family and friends would talk openly with me about my cancer.	____	____	____	____
4. Things would be alot better if the doctor would talk more with me about my illness and treatment.	____	____	____	____
5. Things would be alot better if I knew where I could get financial help.	____	____	____	____
6. My husband and I should get professional counseling.	____	____	____	____

	Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree
7. I talk with others to relieve distress.	____	____	____	____
8. I follow my doctor's orders.	____	____	____	____
9. I work out good alternatives to some of my plans affected by cancer.	____	____	____	____
10. I look forward to the future.	____	____	____	____
11. I will fight my illness any way I can.	____	____	____	____
12. I can look forward to more good times than bad.	____	____	____	____
13. I will soon be just as good as before.	____	____	____	____
14. I do not laugh off everyone's concern about my health.	____	____	____	____
15. I do not try to forget I have cancer.	____	____	____	____
16. I do not spend time at little tasks to keep me from thinking about my illness.	____	____	____	____
17. There is nothing good about having cancer.	____	____	____	____
18. I do not reduce tension I have by overeating, overdrinking, and/or excess drug usage.	____	____	____	____

	Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree
19. I do not hate to go out into public or attend social gatherings because of my illness.	____	____	____	____
20. I will soon get well.	____	____	____	____
21. I will soon be able to enjoy life again.	____	____	____	____
22. I will not die soon of cancer.	____	____	____	____
23. I will not give up because I can make things better for myself.	____	____	____	____
24. My future does not seem dark to me.	____	____	____	____

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