

Interpersonal Relationships and Cancer: A Theoretical Analysis

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This paper focuses on the effect of cancer on the patient's interpersonal relationships, and the ultimate impact of these relationships on the patient's emotional adjustment to the disease. In a detailed theoretical analysis, both the patient's reaction to the illness and others' responses toward the patient are explored. Concerning the patient, the following issues are discussed: (1) fears and uncertainties that develop as one attempts to cope with the diagnosis; (2) the consequent need for clarification and support; and (3) the barriers to receiving validation and support from others. Others' reactions to the patient are hypothesized to be a function of a conflict between (1) their feelings about the illness, which are predominantly negative; and (2) their beliefs about appropriate behaviors to display when interacting with cancer patients (optimism and cheerfulness). This conflict results in behavioral responses that are unintentionally damaging to the patient, including physical avoidance, avoidance of open discussion of the illness, and discrepancies among behaviors. The impact of others' behavior on the patient and the patient's subsequent attempts to solve their interpersonal problems are discussed. The paper concludes with implications for intervention and research.

Recent data suggest that one in four Americans will develop cancer, and two out of three families will be affected by the disease. Cancer kills more people than any other cause except heart disease; and, unlike heart disease, the number of cases of cancer continues to rise each year (American Cancer Society, 1978). It has become increasingly important to understand how people live and cope with cancer because the disease is so prevalent and because survival time has been extended considerably through

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recent medical developments. Moreover, a body of evidence is accumulating that suggests that a cancer patient's psychological reactions can influence his or her physical well-being and ultimate prognosis (see, e.g., Cobb, 1976; Weisman & Worden, 1975).

This paper focuses on one aspect of living with cancer: the effect of the disease on the patient's interpersonal relationships, and the ultimate impact of these relationships on the patient's emotional adjustment to the illness. Three factors have shaped the present approach to this problem: findings from the psychosocial literature; the authors' clinical experience with cancer patients; and predictions from a recent model of reactive depression which draws from research on victims in general (Coates & Wortman, in press). After a brief discussion of these factors, a theoretical analysis of cancer patients' interpersonal difficulties is presented. Relevant evidence for the proposed model is included, and the research and treatment implications are discussed.

BACKGROUND OF THE PROBLEM

Unfortunately, previous work on the psychosocial aspects of cancer does not provide a consistent picture regarding patients' psychological reactions to life-threatening illness. For example, there is considerable disagreement about whether patients go through a series of stages in their attempts to cope with cancer (see, e.g., Kastenbaum & Costa, 1977) and if they do, what stages they experience (for conflicting accounts see Glaser & Strauss, 1965; Kubler-Ross, 1969; Weisman, 1972). There is also little consensus concerning patients' affective responses and coping mechanisms. For example, some investigators (e.g., Craig & Abeloff, 1974; Hinton, 1963; Maguire, Lee, Bevington, Kuchemann, Crabtree, & Cornell, 1978; Peck, 1972) have reported that a large percentage of patients whom they studied manifested moderate to high levels of depression, while other investigations (e.g., Plumb & Holland, 1977) have not found significant depression among cancer patients. Similarly, some researchers (e.g., Bard & Waxenberg, 1957; Polivy, 1977; Sanders & Kardinal, 1977) have reported widespread use of denial among patients attempting to cope with terminal illness; others (e.g., Weisman & Worden, 1976) have found little evidence for denial. (For a more detailed discussion of these issues, see Wortman & Silver, in press.)

These discrepancies highlight two serious problems with the majority of psychosocial studies (cf. Wortman & Silver, in press). The first concerns the quality of the data. A large percentage

of these investigations have been plagued by serious methodological problems, including small sample size, severe attrition, and unreliable measurement techniques. Moreover, it is often difficult to examine these studies critically since many of them fail to provide full information about procedural details such as subject selection or interview protocol. The second problem with many of these studies concerns their lack of theoretical orientation. Little attention has been paid to conceptual variables that might mediate patients' psychological reactions to the disease. Since there appears to be considerable variability among patients in response to cancer, the identification of mediating variables may be helpful in predicting how individual patients will react (e.g., with depression or denial).

Despite these problems with much of the prior research, some consistent findings have emerged. First, cancer patients appear to experience considerable difficulty in their interpersonal relationships as a function of their disease (Cobb, 1956; Dyk & Sutherland, 1956; Glaser & Strauss, 1965; Gordon, Friedenber, Diller, Rothman, Wolf, Ruckdeschel-Hibbard, Ezrachi, & Gerstman, Note 1; Kaplan, Grobstein, & Smith, 1976; Parkes, 1972; Sutherland, Orbach, Dyk, & Bard, 1952). For example, Gordon, et al. (Note 1) asked 136 patients diagnosed with breast, lung, and sarcoma cancers whether or not they had experienced any of 109 problems commonly reported by patients during pilot testing. Of the 20 problems most frequently noted for all three diagnoses, seven were of an interpersonal nature (e.g., "communication with friends about cancer difficult," "discussing future with family difficult," "people acting differently after cancer"). In fact, the second most frequent problem cited was lack of open communication with the family. This problem was mentioned as frequently as suffering physical discomfort (by 63% of sample), and much more frequently than various problems with medications or overall treatment. Similarly, Greenberg (Note 2) conducted systematic interviews with 70 out-patients attending various tumor clinics at a large metropolitan hospital. Patients were asked to describe situations or incidents which had been upsetting to them while in the hospital. Ninety-five percent of the disturbing incidents involved some aspect of interpersonal relationships with physicians or nurses, while the physical pain from cancer and its treatment was mentioned as disturbing in only two percent of the incidents. Both of these studies highlight the importance of the interpersonal environment of cancer patients.

A second consistent finding is that there is apparently a positive

relationship between the quality of a patient's interpersonal relationships and his or her ability to cope with illness. Virtually all of the studies that have examined the predictors of good coping and adjustment to cancer (see, e.g., Carey, 1974; Jamison, Wellisch, & Pasnau, 1978; Sheldon, Ryser, & Krant, 1970; Weisman, 1976) have found that individuals who are able to maintain close interpersonal relationships with family and friends despite their illness are more likely to cope effectively with the disease than individuals who are not able to maintain such relationships.

These impressions from the research literature have been corroborated in our clinical experience with cancer patients. For the past three years, the authors have been serving as facilitators in peer support groups for cancer patients and their family members. These groups are part of a national organization called Make Today Count (see Make Today Count, 1977; Peebler, 1975); their purpose is to provide a setting in which patients and family members can engage in open communication about the problems encountered in attempting to live with cancer. In this context, the authors have been struck by the high frequency of members' problems in the interpersonal sphere, and by the apparent negative relationship between interpersonal difficulties and the ability to cope effectively with the disease.

Findings similar to those on the interpersonal relationships of cancer patients have emerged in other research literatures as well (see, e.g., Cobb, 1976; Litman, 1962; Visotsky, Hamburg, Gross, & Lebovits, 1961; Wortman & Silver, in press). Drawing on these and on the extensive literature on victimization, Coates and Wortman (in press) have recently proposed a model of reactive depression. They maintain that individuals who have been victims of an uncontrollable life event are in special need of support and reassurance from others. There is a large body of research in social psychology to suggest, however, that people are unlikely to be supportive of victims (see, e.g., Lerner, 1970; Lerner, 1971; Lerner & Simmons, 1966; Simons & Piliavin, 1972). There are both cognitive and motivational factors which lead individuals to dislike, blame and avoid victims. Yet, we are also socialized to be "kind" to others who have suffered misfortune, and victims can arouse our sympathy. What most victims receive from others, therefore, is an unsettling mixture of negative and positive responses. On the one hand, people try to offer reassurance and support, and on the other hand, they exhibit avoidance behaviors and negative affect. Positive responses are mingled with both subtle and clear-cut signs of rejection. According to Coates and

Wortman (in press), repeated exposure to this feedback can undermine a victim's feelings of self-worth, and can contribute greatly to the problems already being faced.

*A THEORETICAL PERSPECTIVE ON THE INTERPERSONAL
ENVIRONMENT OF THE CANCER PATIENT*

Although some researchers have focused on the interpersonal relationships of other ill populations (e.g., Coyne, 1976a, 1976b; Lemert, 1962; Lewinsohn, 1974), little attention has been directed toward the social environment of cancer patients. Because of the stigma associated with cancer, cancer patients may be even more likely than most victims to elicit feedback from others that is inconsistent, confusing, and ultimately destructive. An adaptation of the general model proposed by Coates and Wortman (in press) may be useful in understanding the impact of cancer on interpersonal relationships and subsequent adjustment. The remainder of this paper will discuss that model as it can be applied to the cancer patient.

A Brief Overview of the Model

A person diagnosed with cancer is likely to be highly fearful and uncertain. The intensity of their feelings and anxieties may lead many patients to worry that they are coping poorly or losing their grip on reality. They experience a need to clarify the meaning of their responses to the illness in order to learn whether their reactions are reasonable and normal. Patients also experience intense needs for social support. Unfortunately, there are communication barriers in the social environment that make it especially difficult for cancer patients to attain the clarification and support they need.

The reactions of others who are prominent in the life of the patient (family, friends, health care personnel) are likely to be determined by two factors: by their feelings about the patient and his or her illness, and by their beliefs about appropriate behaviors to display when in the patient's company. While their feelings about the patient's illness are largely negative, they believe that they should remain positive, optimistic and cheerful in their interactions with the patient. This conflict may result in behaviors which are unintentionally harmful to the patient, including (a) physical avoidance of the patient; (b) avoidance of open communi-

cation, especially about the disease and its effects; and (c) discrepant, contradictory behaviors.

The patient, in turn, interprets this ambiguous and negative social feedback as rejection, which is experienced at the very time when communication with and support from others is especially important. At this point, patients may try to enhance the support and attention they receive from others by exaggerating and stressing their difficulties, or by hiding their problems from others and indicating that they are coping well. Unfortunately, these solutions only serve to make it more difficult for others to know how to react to the patient, and may therefore exacerbate their interpersonal problems rather than solving them.

In the following sections, the links of this model are described in more detail, and relevant evidence is presented. Interventions which may prevent or correct these communication problems are discussed, and implications for subsequent research are explored.

The Cancer Patient's Situation

Patients' fears and uncertainties. The individual who recently has been diagnosed as having cancer is likely to be profoundly fearful and uncertain about many things. An environment that was formerly at least tolerable has now become unpredictable and threatening. The patient's former assumptions and beliefs about the environment and the self are brought into question. He or she is confronted with a web of fears, including fear of pain, of recurrence, of progressive deterioration, of dependency on others, and of death (Davies, Quinlan, McKegney, & Kimball, 1973; Hackett & Weisman, 1969; Katz, Weiner, Gallagher, & Hellman, 1970). Patients worry about whether the doctors have been honest with them, whether they are receiving the best care, and how their illness will affect their family. They are also forced to contend with a variety of physical changes and problems, which may include pain, energy loss, disfigurement, nausea, hair loss, and malodors. Clearly such changes can be deeply unsettling and can have a profound effect on the patient's self-concept.

Within the context of this uncertainty about the environment and self, the cancer patient is often called upon to function more competently than ever before in making the many decisions that confront him or her. These may range from questions about what hospital to enter, which physician to contact and what treatment to have, to questions about what to tell their children, friends and co-workers. Many patients are overwhelmed by the number and complexity of decisions to be made. While the

decisions required of the cancer patient are similar to those that people make in everyday life, they are linked to graver consequences, and the patient may be emotionally and physically less able to tackle them. In addition, a large number of these decisions concern matters with which the patient has no expertise or prior experience. There is considerable ambiguity within the field of medicine about how to treat certain types of cancer, so there may be no clear-cut answers to some of the problems facing the patient. Thus, it will often be impossible for the patient to feel confident that the chosen alternatives are the best ones.

Countless descriptive accounts (e.g., Milton, 1973; Rollin, 1976) suggest that the diagnosis of cancer elicits terror, confronting the patient with the prospect of a shortened future, rapid physical deterioration, and perhaps a painful and lingering death. There is also evidence that the diagnosis of cancer leads to ambiguity and confusion for the patient (e.g., Greenberg, Note 2; Orbach & Tallent, 1965; Quint, 1965; Sutherland et al., 1952) and that this is distressing.

Patients' needs for clarification and support. Because of the uncertainties they face and because their sense of self is threatened, many cancer patients experience intense needs both to clarify what is happening to them and to be supported and reassured by others. The intensity of their fears and feelings may lead many cancer patients to worry that they are coping poorly or are losing their grip on reality. They experience a need to understand the meaning of their responses. Are their reactions to the crisis reasonable or "normal"? How should they be responding? How long will their fears and anxieties last?

One way to learn more about the meaning and appropriateness of various behaviors is through exposure to others who are in a similar situation. As Festinger (1954) and Schachter (1959) have pointed out, confusion and ambiguity can often be resolved through social comparison. For example, a patient can learn through comparison with others that it is normal to become angry or depressed after diagnosis, to fear recurrence, and to be avoided by some of one's former friends. The patient can attain comparison information from "educational materials" (articles, books, or specially prepared pamphlets about cancer, films or television programs, lectures, symposia or public meetings), or from face-to-face encounters with other patients. Some of these sources may provide general (normative) information about cancer patients' reactions to certain treatments or problems; others may include individual accounts or "case studies" in which a patient describes

his or her personal reactions to the disease.¹ All of these can help the patient clarify his or her feelings by providing information about problems typically encountered, common or "normal" reactions, and strategies which might be employed to cope with them.

A second way that patients can help to clarify the meaning of their feelings is to discuss them frankly and openly with a sympathetic listener. Articulating one's fears and feelings may be the first step in understanding them, and in working out strategies for coping with them. By allowing the patient to express his or her concerns, by acknowledging these concerns and by acting as a "sounding board" for the patient, relatives, friends, or health care personnel can help the patient to interpret and manage his or her experiences.

A third, and perhaps best, way for patients to clarify their feelings is to have the opportunity to discuss these feelings and personal reactions with others who can provide feedback about their meaning and appropriateness (e.g., other cancer patients who have shared many of the same experiences as the patient, or health care professionals who have had considerable experience with the patient's disease). Because this approach enables the patient to raise the issues that are of greatest concern to him or her, it would seem to have an advantage over mere exposure to comparison information, or availability of a "sounding board."

In summary, receiving comparison information, opportunities to ventilate, and social interaction where feedback is received are three ways the cancer patient can clarify the uncertainty and confusion experienced. Few studies have probed patients' needs to clarify their responses. However, there are indications that under many circumstances, patients would like to receive more information about treatments, side effects, and other reactions to the disease than they are normally given (Bloom & Ross, Note 3; McIntosh, 1974; Sheffer & Greifstein, 1969).

There is also evidence to suggest that patients would like additional opportunities to discuss their problems (American Cancer Society, Note 4; Kleiman, Mantell, & Alexander, 1977).

¹Some research summarized by Nisbett and Wilson (1977) suggests that although consensus information, or summary statistics about how others behave may be more valid than a single case study, individuals may be more influenced by a case study. According to Nisbett and Wilson, this is because the information presented in a case study is more vivid and therefore more personally involving.

For example, Mitchell and Glicksman (1977) conducted an interview study of 50 cancer patients undergoing radiation therapy. Only 22 patients were able to identify a person with whom they could discuss their emotional problems, and 86% of the patients wished to be able "to discuss the situation more fully" with someone. There are only a few studies of cancer patients' interest in discussing their problems with other patients. Although the evidence is not entirely consistent (see Mitchell & Glicksman, 1977), it seems to suggest that patients generally do wish to talk to others with the same disease or problem (Binger, Ablin, Feuerstein, Kushner, Zoger, & Mikkelson, 1969; Bozeman, Orbach, & Sutherland, 1955).

The uncertainties and fears of the patient are likely to result in an enhanced need for social support as well as an increased need for clarification (Lieber, Plumb, Gerstenzang, & Holland, 1976; Schwartz, 1977; Thomas & Weiner, 1974). As the patient contends with the prospect of a shortened life, unpleasant and possibly mutilating treatments, and physical deterioration, the need for support may grow stronger. In fact, one of the greatest fears patients have during the early stages of cancer is that they will be rejected and abandoned by loved ones (cf. Sutherland & Orbach, 1953).

The available evidence suggests that information, opportunities for discussion, and perceived support are not only desired but also are beneficial to the patient. Concerning the value of information, a large number of well-controlled investigations have been conducted on patients with several kinds of medical problems. Although a thorough review of these studies is beyond the scope of this paper, the majority of these experiments have suggested that patients who receive information about what to expect prior to treatment cope better than uninformed control patients (see, e.g., Egbert, Battit, Welch, & Bartlett, 1964; Janis, 1958; Johnson & Leventhal, 1974; Langer, Janis, & Wolfer, 1975; Sime, 1976; Vernon & Bigelow, 1974). The information received may serve to reduce distress by assisting patients in interpreting their own reactions as normal.

The value of open discussion is less well-documented, but, the available evidence suggests that this is advantageous (see Wortman & Silver, *in press*, for a review; Binger et al., 1969; Kaplan et al., 1976). There is also some research to suggest that discussions with similar others are beneficial (Binger et al., 1969; Bozeman et al., 1955). In fact, Bozeman et al. (1955) reported

that other parents with leukemic children "were regarded by most mothers as the most important source of emotional support" (p. 15). Because most of these studies are characterized by small sample size and inadequate comparison groups, however, these conclusions are in need of further documentation. Several studies have provided evidence that perceived support is helpful to the cancer patient (see, e.g., Carey, 1974; Jamison et al., 1978; Weisman & Worden, 1976). In a study of 41 mastectomees, for example, Jamison et al. (1978) found that women who reported better emotional adjustment also perceived their spouses, children, physicians, and nurses as more supportive than women with lower self-reported adjustment.

Although most of the studies suggesting the value of open communication and support are correlational, one intervention study has addressed this problem (Bloom & Ross, Note 3). Twenty-six women were provided with a comprehensive treatment consisting of information, opportunities for ventilation of their feelings, and support from a team of medical and psychosocial professionals. Two months following surgery, these women had higher self-esteem and self-efficacy scores on scale assessments than a comparison group of patients who did not receive the treatment.

Barriers to social validation and support. Unfortunately, while persons diagnosed as having cancer may have considerably greater needs than others to gain information from social interaction, they are likely to have more difficulty doing so. In most cases, cancer patients have limited access to others suffering from comparable problems. They may be exposed to newspapers and other media coverage of cancer. However, such presentations may be biased toward patients who have a positive attitude and who are coping well. They may encounter other patients by chance in a hospital waiting room or doctor's office, but these settings are ones in which only superficial exchanges are likely to take place.

In fact, three investigations confirm that cancer patients and mothers of children with leukemia interact very little with one another in hospital waiting rooms (Hoffman & Futterman, 1971; Mitchell & Glicksman, 1977; Peck & Boland, 1977). The majority of these patients spent no time talking to other patients during waiting periods before treatments, or spoke only of "trivial subjects" during this time. This type of exposure to others with cancer could actually be detrimental, since it could lead patients

to the erroneous conclusion that most people have few problems in coping with cancer and that their own confusion, doubts, and fears are deviant and abnormal.²

This research suggests that intimate discussions with other cancer patients are unlikely to occur spontaneously. Moreover, since cancer is such a stigmatizing disease, many patients may feel inhibited about seeking out similar others or publicly identifying themselves as cancer patients. Thus, patients are usually forced to rely on health care professionals, family members, and friends for validation and support. In most cases, dissimilar others who are more accessible tend to be substituted for similar others (that is, other cancer patients).

While dissimilar others such as family, friends, and medical staff are more likely to be available to the patient than other cancer patients, certain factors may inhibit the patient from approaching those people in their immediate social environment. Cancer patients may be afraid to share their feelings and fears with others. Although there is little empirical evidence of this in cancer patients, White, Wright, and Dembo (1948) found that disabled men were reluctant to discuss their injury openly, despite their desire to communicate and their need to be understood and accepted. Two factors may inhibit cancer patients from discussing their feelings despite their interest in doing so. Patients may feel that it is inappropriate to express emotional concerns to their doctors, both because they feel doctors are too busy for such conversation (Mitchell & Glicksman, 1977) and because they believe the doctor will react negatively if they express their feelings. In fact, being silent, passive, and accepting is the perceived role of a "good patient" (cf. Greenberg, Note 2; Tagliacozzo & Mauksch, 1972; Taylor, 1979). Cancer patients also may fear that open discussion of their feelings about the illness will upset or hurt others. This strategy of protecting others may be especially strong toward family members, since they are perceived by the patient as being overburdened by their illness (cf. Harker, 1972; Schwartz, 1977). Thus, as much as they may need validation and support,

²Perhaps for this reason, the majority of the patients in Mitchell and Glicksman's (1977) study felt that it would be undesirable to spend additional time with other patients. But almost all of the patients who felt that way had not engaged in open discussions with other patients in the waiting room. Most of the patients who had discussed their problems openly with other patients in the waiting room expressed a desire to spend additional time with other patients to discuss common problems.

cancer patients may hesitate to approach others.

Although the specific reasons have not been explored, there is some evidence that intimate discussions between cancer patients and others do not occur (Bard, 1952; Gordon et al., Note 1; Jamison et al., 1978; Mitchell & Glicksman, 1977; Sanders & Kardinal, 1977; Vachon, Freedman, Formo, Rogers, Lyall, & Freeman, 1977). On the basis of this evidence, it appears that the needs of cancer patients for social interaction are frequently not met. The following analysis of the reactions of others to the cancer patient offers some additional perspectives on why these problems occur.

Reaction of Others to the Cancer Patient

What types of responses do cancer patients generally receive from those in their social environment? A person's behavior toward a cancer patient is likely to be affected by two factors: by feelings with regard to the patient, and by prior assumptions about how cancer patients should be treated. For many reasons that are detailed below, most individuals are likely to experience negative feelings about a cancer patient's situation. Despite these feelings, most people believe that it is important to be cheerful, optimistic, and encouraging when interacting with a person who is ill. Because the behaviors people see as desirable are discrepant with their private feelings, they are often very uncomfortable about the prospect of interacting with the patient. Their discomfort may cause them to behave in ways that are distressing to the patient. They may avoid the patient, avoid open communication regarding the patient's difficulties, or emit conflicting behavioral cues when in the patient's presence.

Feelings toward the cancer patient. For a variety of reasons, others' feelings about cancer patients are likely to be negative. Some of these feelings are specific to cancer; others may occur whenever individuals are exposed to victims of undesirable life events. Cancer appears to be somewhat unique in its ability to arouse fear and feelings of vulnerability. In health surveys, individuals have expressed considerable fear of developing cancer and greatly underestimate their chances of contracting and dying from the disease (Knopf, 1976).

The disease also seems to evoke physical aversion and disgust in others, particularly when it is associated with mutilating surgery or physical deterioration. These feelings may be increased when one encounters striking and visible changes in a previously healthy person. Even family members report being taken aback by changes

in the appearance of the patient. Aversion may also stem from individuals' fear that they will catch the disease. Indeed, patients describe instances where they have been the only one at a party to receive paper eating utensils, or where they have been asked not to use public rest rooms or swimming pools (see e.g., Kelly, 1975; "Cancer: More than a disease," 1977). The fact that causes of cancer are not fully understood, combined with recent episodes of geographical clustering of cancer incidence, have contributed to this belief. Indeed, Kleiman et al. (1977) suggest that this myth about contagion is pervasive even among health care providers and is a major cause of avoidance and rejection of the patient.

In addition to fear, dread, and aversion, cancer is likely to arouse feelings of anger and sadness, even depression, about what is happening to the patient as well as concerns for the patient's future. The closer the relationship between a patient and another person, and the more dismal the prognosis, the more intense these empathic and sympathetic reactions may be.

The social psychological literature suggests additional motivational and cognitive factors which may lead individuals to react negatively to people who have experienced negative life events. Theoretically, these principles should apply to any situation in which people are confronted with others who have suffered in some way, including interactions with cancer patients. Lerner and his associates (1970, 1971) argue that individuals are motivated to believe in a "just world" in which people "get what they deserve, and deserve what they get." When exposed to a fellow subject who is randomly assigned to receive painful electric shocks, for example, subjects derogate or blame the victim (Lerner, 1970, 1971; Lerner & Simmons, 1966; Simons & Piliavin, 1972). As a result of these investigations, Lerner has argued that if we can believe that people do not suffer unless something is wrong with them or their behavior, we will feel protected from undeserved suffering ourselves (see also Walster, 1966). Since having cancer is regarded as an extremely undesirable fate, individuals may be strongly motivated to protect themselves by attributing the disease to others' undesirable personal characteristics or their past behavior. Such reactions toward cancer patients are probably most prevalent among strangers and acquaintances.

A second factor that may contribute to a person's motivation to derogate an individual who is suffering is that such an attitude more or less absolves the derogator from any guilt for not helping the suffering person. As many health care providers can attest,

dealing with a cancer patient who is depressed, fearful, and in pain can be a very stressful experience. Those in close proximity to the patient may try to offer reassurances or help in various ways, but become frustrated if they notice little improvement in the patient's condition as a result. Attributing the patient's negative feelings and fears to his or her own inadequacy in coping with the disease can relieve one of any personal responsibility for being unable, or even unwilling, to help. Derogation of this type is especially likely to come from family members and health care professionals, who have frequent and continuing contact with the patient. Although there have been few empirical studies on this issue, a number of descriptive accounts (e.g., Kalish, 1977) corroborate this reasoning.

In addition to the motivational factors, there may be cognitive or information processing biases that lead observers to derogate and blame cancer patients. One such bias has been suggested by Jones and Nisbett (1971) in their influential paper on actor-observer differences in the attribution process. Jones and Nisbett (1971) have argued that actors tend to attribute the causes of their behavior to aspects of the situation, while observers attribute the actor's behavior to stable dispositions or personality characteristics. Theoretically, this difference occurs because the actor has more information than does the observer about the situational factors that are impinging on him or her, whereas the observer focuses on the behavior itself. For example, a patient who complains that his or her doctor was unsympathetic will have more information about how the doctor behaved than will a family member or friend who was not present during the examination. For the observer, the complaint itself is more salient. Because the observer may give insufficient weight to situational determinants of the patient's behavior, the behavior may be attributed to dispositional weaknesses. For example, an observer may reason that the cancer patient is complaining because he or she is "weakwilled, selfish and cowardly."

Since they are confronted with a genuinely stressful and aversive experience, many of the behaviors manifested by a cancer patient are likely to be negative (e.g., fear, depression; see Harker, 1972). Thus, observers' bias toward dispositional attributions will often lead them to draw negative inferences about the patient. Such a bias may be especially prevalent among family members and health care professionals, since they are more likely to witness negative behaviors than casual acquaintances or friends. Over

time, this attributional tendency may result in the accumulation of tensions between the patient and others that are difficult to correct or counteract.

A given individual may even experience several different kinds of negative feelings toward a person with cancer. The spouse of a colostomate, for example, may feel physical aversion regarding the condition, sadness that the spouse is suffering, and anger and resentment that he or she must spend so much time caring for the patient (cf. Dyk & Sutherland, 1956; Sutherland et al., 1952). In describing these negative feelings, we do not mean to paint others as intentionally cruel, unsympathetic, or unfeeling toward cancer patients. We do believe, however, that certain motivational factors and information processing errors may unwittingly result in negative reactions to the patient, even for individuals who have strong feelings of love, concern, and sympathy for him or her.

Beliefs about appropriate behavior toward the cancer patient.

Although most people have had little direct, relevant experience in interacting with cancer patients, they often hold prior assumptions about how they should behave toward the patient. Some of these notions come from their acceptance of social norms and dictates for behavior toward those who are sick or dying. Others come from their conceptions about what types of comments and interactions are likely to be most helpful to the patient. Regarding the former, people are socialized to show concern for others who are seriously ill, and they learn ritualized behaviors of politeness such as visiting, calling, or sending cards. Consequently, they may feel strong obligations to behave in these ways toward a cancer patient. For example, if one's co-workers go to visit a fellow worker who is hospitalized with cancer, one may feel obligated to do the same.

Regarding their conceptions about what is beneficial for the patient, many people seem to feel that it is desirable for the patient to remain as cheerful as possible. It is considered wrong for cancer patients to discuss problems they are having in coping with their illness, or to focus on a negative prognosis. It is often believed that such discussions will be depressing to the patient, will encourage self-pity, or will undermine the patient's motivation to keep fighting the disease.

The assumption that the patient should avoid thinking or talking about the negative aspects of his or her situation, and attempt to remain as cheerful and optimistic as possible, appears to be quite prevalent. According to Kastenbaum and Aisenberg

(1972), a majority of nurses and attendants on a geriatric ward reported changing the subject when patients tried to discuss their feelings about death. The most frequent reason they gave for doing this was that they wanted to "cheer up" the patient, and they felt that the best way to do so was to focus the patient's attention on something else (see also, Quint, 1965). Similarly, Harker (1972) and Garfield (1977) have suggested that most people believe open discussion of cancer patients' difficulties would upset their emotional equilibrium. Kalish (1977) has argued that family members believe discussion about cancer or death will make the patient uncomfortable.

Research with other populations also suggests that people believe that those who discuss their problems are coping poorly, and for this reason, victims should be discouraged from talking about any difficulties they are having. Coates, Wortman, and Abbey (in press) found that rape victims who made a brief negative comment about the incident six months after its occurrence were rated as less attractive, and were regarded as more maladjusted, than victims who did not. Respondents in some studies have reported that they are pressured by others to remain cheerful and pleasant. For example, Dyk and Sutherland (1956) quote one patient who felt that his family members "would never have the patience to listen to the whole story of my illness . . . their desire was always to hear from me that I was all right" (p. 74). Similarly, Glick, Weiss, and Parkes (1974) have reported that the widows in their survey were continually admonished not to give way to their grief, but to focus on all that they had to live for. Interestingly, most widows reported that such advice was not helpful. Those friends and relatives who encouraged the honest expression of their feelings were more likely to be regarded as helpful.

In fact, there are good reasons to question the assumption that expression of negative affect is always maladaptive for the patient. As discussed previously, most cancer patients are highly motivated to share their feelings rather than conceal them so that they can clarify what is happening to them. Moreover, there is at least some evidence to suggest that the opportunity to express one's negative feelings is associated with good adjustment (see, e.g., Bloom & Ross, Note 3). Dwelling on the negative aspects of one's situation or over-indulgent complaining may be unproductive, but constructive expression or "ventilation" of the difficult problems and emotions one is experiencing is likely to be highly beneficial. Much of the clinical literature advocates discussing

the problems one is having with others (cf., Klagsbrun, 1971; Schwartz, 1977).

Conflicts about how to behave toward the cancer patient. As described above, people harbor negative feelings about cancer and cancer patients, but believe these feelings should not be expressed to the patient. Instead they assume that they must act cheerful and encouraging in their dealings with a person who has cancer. This conflict affects the frequency and quality of time that others spend with cancer patients.

The conflict is likely to produce a great deal of ambivalence in most people regarding the prospect of coming into contact with someone who is seriously ill. Should one obey his or her desire to deny or avoid the unpleasantness associated with the cancer patient? Or should one try to hide his or her negative feelings, and attempt to reach out to the patient, to be positive and cheerful? These discrepant feelings may be immobilizing, and patients may interpret such conflict and indecision as active avoidance of them. Others may resolve this ambivalence by deciding to contact the patient. Still others may be required to spend time with the patient (as is generally the case with family and medical personnel), or may "force themselves" to visit because they believe it is the right thing to do.

In all of these cases, the interaction is likely to evoke a certain amount of anxiety. Contact with the patient force people to confront their negative feelings; indeed, it often heightens these feelings since the patient's suffering and deterioration are usually more evident in face-to-face interaction. At the same time, people assume that every effort must be made to control their feelings, and conceal their anxiety and distress. Parkes (1972) has noted that family members worry constantly that they will "break down" and "betray their feelings" to the patient. Direct exposure to another who is suffering, coupled with an ever-present concern that one will reveal his or her feelings, or "say the wrong thing," makes most encounters with the patient awkward, uncomfortable, and tense. Furthermore, many people have had few encounters with others who are seriously ill, and thus have little experience to guide them in this difficult situation.

Behaviors of Others Toward the Cancer Patient

Others' ambivalence, confusion and discomfort often lead them to behave in ways that are unintentionally damaging to the patient's welfare. There is considerable evidence that people avoid cancer patients, that they discourage open communication

with the patient, and that they give off conflicting behavioral cues when in the patient's presence.

Physical avoidance. Several investigators have noted that physicians and nurses avoid dying patients (see Schulz, 1978, for a review). The results of one study revealed that nurses took longer to answer the calls of dying patients than other individuals who were hospitalized (LeShan, reported by Kastenbaum & Aisenberg, 1972). Artiss and Levine (1973) reported that doctors were uneasy about encounters with dying patients and often dreaded and avoided them. A cancer patient may also experience reduced physical contact with his or her family. Sutherland et al. (1952) found reduced sexual activity among male and female colostomy patients who had survived 5 to 15 years after surgery. Similarly, Dyk and Sutherland (1956) found low levels of physical assistance from spouses of colostomates. In most cases, the patients desired more help from their spouses than they were receiving. Thus, physical avoidance may occur at a time when cancer patients especially need physical contact as a sign of reassurance (cf. Lieber et al., 1976).

Avoidance of open communication about the disease. As noted earlier, a number of empirical studies suggest that open communication is avoided (Jamison et al., 1978; Sanders & Kardinal, 1977; Vachon et al., 1977). For example, Jamison et al. (1978) found that 89% of the mastectomies in their sample reported having had little or no discussion with spouse or significant other prior to surgery, 87% reported little or no discussion while hospitalized, and 50% reported little or no discussion after returning home. It is not clear from these investigations whether the lack of open communication is brought about by others or by the patient. However, other studies suggest that it is common for family members, friends, and medical staff to discourage open communication and that patients see this as a problem (cf., Bard, 1952; Gordon et al., Note 1, Mitchell & Glicksman, 1977; Kastenbaum & Aisenberg, 1972; Pearlman, Stotsky, & Dominick, 1969).

Some investigations have indicated that family, friends, and medical personnel not only avoid discussions of patients' feelings but may exert considerable influence on patients to conceal their feelings (cf., Dyk & Sutherland, 1956, Quint, 1965). For example, Quint (1965) interviewed 21 mastectomy patients five times post-surgery and collected observations on patient-staff interactions. She found that physicians and nurses made it difficult for patients to express concern or ask questions by directing the conversation into "safe channels." Both patients and nurses reported that nurses

did not permit open communication. Patients also reported that family and friends blocked them from discussing their illness. Barriers to verbal communication were greater the more extensive the cancer. The tendency on the part of medical staff members to evade conversations of intimate and negative nature is so pervasive that entire books have been written on how to "manage" patients' behaviors (e.g., Garner, 1966). There is less evidence on family behavior toward the patient (e.g., Bard, 1952; Binger et al., 1969; Dyk & Sutherland, 1956; Glaser & Strauss, 1965; Klein, 1971; Quint, 1965), but available studies suggest that significant others are as likely as medical caregivers to attempt to control the level of discussion with the patient.

There are a number of reasons why those in the patient's social network may discourage open discussion with the patient. Open communication may be avoided because it is not consistent with most people's beliefs regarding what is good for the patient (Garfield, 1977; Kalish, 1977; Kastenbaum & Aisenberg, 1972). Individuals also may wish to avoid listening to the patient's feelings simply because they are unpleasant (Buehler, 1975; Kastenbaum & Aisenberg, 1972). Open discussion may also serve to intensify negative feelings which are already present. Thus, if a family member is upset about a spouse who is dying, it may add to his or her distress to learn that the patient is afraid to die. Finally, others may wish to avoid listening to the patient's difficulties because it is even more difficult to control one's own feelings in these situations (cf. Parkes, 1972).

Discrepancies in behavior toward the cancer patient. Because of the underlying conflict between one's negative feelings about the cancer patient, and one's beliefs about how to respond to him or her, individuals are likely to show discrepancies in their behavior when they do interact with the cancer patient. Especially likely are discrepancies between verbal and nonverbal behaviors directed toward the patient. Individuals interacting with the cancer patient may make a gallant effort to appear agreeable, optimistic and cheerful. While most people can force themselves to make optimistic statements, the nonverbal behaviors that accompany these statements may be more difficult to control. Some investigators have argued that nonverbal behavior is a major indicator of one's true feelings (see, e.g., Argyle, 1975). Thus, the negative affect experienced by those interacting with cancer patients may well be manifested in their nonverbal behavior.

To our knowledge, no one has systematically investigated the nonverbal behaviors that occur when well persons interact

with cancer patients. However, experiments dealing with confrontations between able-bodied and handicapped individuals seem directly relevant. These studies have shown that the able-bodied often express their discomfort in such situations by more rigid and controlled motor activity, fewer smiles, greater interpersonal distance, and earlier exits than they demonstrate when interacting with other able-bodied individuals (see, e.g., Farina, Holland, & Ring, 1966; Kleck, 1968; Kleck, Buch, Goller, London, Pfeifer, & Vukcevic, 1968; Kleck, Ono, & Hastorf, 1966). If these results are generalizable to persons with other kinds of stigmata, there may be a considerable discrepancy between others' verbal statements and their nonverbal behaviors toward cancer patients. For example, an individual may offer reassurance while maintaining an awkward interpersonal distance or while talking in a nervous voice.

There is evidence that patients are aware of these negative nonverbal behaviors and find them disturbing. For example, in an interview study of 50 patients hospitalized with chronic illnesses including cancer, Cobb (1956) found that patients easily picked up signals of nurses' attitudes from their tone and manner, and wanted nurses to transmit concern and compassion nonverbally. Perhaps for this reason, the importance of nonverbal communication modes in medical settings is being increasingly stressed (see, e.g., Bennett, 1977; DiMatteo, 1979; Friedman, 1979; Parkes, 1972; Verwoerd, 1966).

The conflict between individuals' negative feelings and their desire to respond positively to the patient may also be evident in discrepancies between verbal behaviors in a given context. For example, a person may be supportive to a cancer patient one moment and rejecting the next. One of the women in the authors' support group reported that her daughter once said to her, "Does your arm hurt, Mother? Well, don't tell me if it does." Discrepancies may also occur between behaviors in different situations and at different times. For example, a friend who has not visited the patient for weeks may suddenly show up and lavish attention on the patient. Or there may be discrepancies between a person's expressed intentions and his or her subsequent behaviors. People often promise to call or to visit again soon, but do not get around to carrying out these promises, perhaps because of their underlying negative feelings.

Discrepancies in behavior may be especially likely to come from family members, since it is the family members who generally have the most sustained contact with the patient (Aitken-Swan,

1959; Binger et al., 1969; Dyk & Sutherland, 1956; Klein, Dean, & Bogdonoff, 1967). No matter how much they love the patient, most family members are bound to resent the enormous responsibility thrust upon them and the changes the ill person has brought about in their lives. They frequently become emotionally drained from trying to keep pace with rapid fluctuations in physical condition, mood, and coping strategies of the patient. Frustration results from efforts to help the patient which have little impact on the course of a progressive disease. Physical exhaustion is common among close caregivers, and the strain of financial difficulties often accompanies it. A family member's own needs, interests, and problems are neglected as they struggle to stay on top of a complicated and demanding situation.

Investigations of the effect of the disease on family relationships (Aitken-Swan, 1959; Dyk & Sutherland, 1956) have suggested that many family members make sincere efforts to be supportive and loving to the patient. But because of all the pressures upon them, even the most patient and understanding family member is likely to direct occasional negative outbursts toward the patient. As the stress of interacting and caring for a suffering and ill person continues and no improvement is in sight, these outbursts may become more frequent. Yet they conflict with the family member's feelings about how the patient should be treated, and thus, they are likely to be followed by strong feelings of remorse, and by displays of love and concern for the patient.

Impact of Other's Behavior on the Patient

When a person learns he or she has cancer, that knowledge produces a need for clarification and social support. As the disease progresses and the patient attempts to cope with all of the events ensuing from the illness and its treatment, the need for satisfying social interaction becomes more intense. But most cancer patients find themselves in a situation where their needs for information and social support are thwarted at every turn.

The changes in their social relationships are likely to be profound. Casual friends and acquaintances may begin to avoid the patient completely. When people do visit, any attempts to provide reassurance and support are unlikely to be convincing. Despite others' best intentions, their interactions with the patient are often characterized by awkwardness, hesitancy, uncertainty, and tension. Many of those who interact with the patient may attempt to keep the conversation superficial and may thus avoid the topics that are really on the patient's mind. While this evasion

may often be motivated by a concern for the patient's welfare, the patient may infer that others are not really interested in his or her feelings. Friends, family members, and health care professionals are likely to voice reassurance on the surface, but manifest negative nonverbal behaviors as well as inconsistencies in behavior over time. Moreover, their efforts to be reassuring and agreeable may often backfire into an oversolicitous and patronizing attitude toward the patient. Even from family members, patients may receive mixed messages and occasional negative outbursts as the stress of caring for an ill person takes its toll. Positive feedback that is laced with subtle and sometimes overt negative signs can leave the patient feeling hurt, rejected and certainly confused. As this cycle continues, the patient's need for social validation and support may reach overwhelming proportions.

Since they elicit signs of rejection from virtually everyone, and since the negative feedback is fairly consistent across situations and over time, patients may draw the conclusion that they are worthless, unlovable and despicable. The impact of consistently negative or ambiguous feedback on the patient's self-esteem can be devastating (cf. Dyk & Sutherland, 1956). Over time, patients may come to internalize the views they perceive others to hold (cf. Kleiman et al., 1977). What Goffman (1963) has stated about the stigmatized in general may hold for the cancer patient: he or she may incorporate the views of others into his or her identity, and begin to feel shame and guilt, self-blame, self-derogation, and self-hatred. Mastrovito (1972), for example, has speculated that more than half of the patients treated in his clinic over the past three years expressed self-revulsion and negative self-concepts. Ultimately, the self-doubt and isolation which result from disruption of one's social relationships can contribute greatly to the cancer patient's distress.

Patients' Attempts to Solve the Interpersonal Dilemma

Because the disease and its associated problems may leave the patient physically and emotionally drained, most patients do not have a great deal of energy to divert to improving their social relationships. Yet, as the need for information, clarification and support becomes more desperate, the individual with cancer may try any of several strategies to break out of the crippling interactional patterns that we have been describing. For example, he or she may exaggerate the negative aspects so that others will respond. Unfortunately, the more a patient dwells on his

or her problems, the more alienated and rejecting others are likely to become (cf. Lerner, 1970, 1971).

At some point, it may occur to the patient that attaining useful information about one's own responses is probably incompatible with getting acceptance and approval from others. While the best way to validate one's feelings may be to discuss them with others, the best way to get support may be to indicate that everything is fine, and that one is coping well. Thus, the patient may try to stave off the rejection and avoidance of friends by adopting a more positive self-presentational strategy. Hackett and Weisman (1969), in a paper on reactions to imminent death, argue that the patient "learns that to pursue his doubts by asking questions seldom yields more than uneasiness between himself and those upon whom he depends for companionship. Therefore he stops asking and becomes a player in the deathbed drama in which optimism is the theme" (p. 304). And from the cancer patient's point of view, Rollin (1976) recalls, "I got many congratulations for being so brave and cheerful. I liked that, so I got more brave and cheerful. And the more brave and cheerful I was, the more everyone seemed to love me, so I kept it up. I became positively euphoric" (p. 70).

There are two problems with this approach to the patient's dilemma. First, this may stop avoidance responses from some people (e.g., those who cannot deal with the patient's pain and suffering), but not others (e.g., those who fear the illness is contagious). Second, since the patient is aware that he or she is using false pretenses to gain approval from others, any support received may provide little information to the patient about his or her true worth (cf. Jones & Wortman, 1973). In fact, a general problem for the patient who wishes to correct these communication problems is that there is often little relationship between his or her behavior and the responses of others. While feedback from others may be predominantly ambiguous and negative, it stems as much from the anxiety or distress of others as from the patient's actual behavior. Thus, the patient's attempts to alter negative feedback may be met with a seemingly random pattern of responses. As a consequence, the patient may come to expect negative or ambiguous feedback from others. Any positive feedback may have little impact on the patient, since it is likely to be attributed to the patient's obvious need for it or the self-presentational strategy employed to attain it.

So, most cancer patients find themselves in an uncomfortable situation, a "catch-22": either they can express their feelings and

be themselves, thereby incurring others' avoidance and rejection, or they can enact a charade, pretending that everything is fine, and obtain at least some support from others. Because neither of these alternatives is satisfactory, the patient may vacillate between them, sometimes putting on a good face, and sometimes confronting others with their pain and anxiety. This vacillation, of course, pollutes the social environment still further and makes it even more difficult for friends and relatives to know how to respond to the patient. Most patients are not in a position to test the hypothesis that *all* cancer patients are treated in this manner by friends and loved ones, so they stay trapped within this dilemma indefinitely. If it continues unchecked long enough, this process may lead to complete withdrawal from the social environment, and to severe and chronic depression.

*IMPLICATIONS FOR TREATMENT INTERVENTIONS
AND FOR SUBSEQUENT RESEARCH*

Many authors have talked about the social isolation of the cancer patient (e.g., Giacquinia, 1977; Klagsbrun, 1971). In principle, this process of social isolation may be stopped or reversed at any point by natural circumstances or by therapeutic intervention. Some patients may not experience this social breakdown as acutely as others because of exceptionally sensitive relatives or friends with whom they can openly communicate without rejection or avoidance. Occasionally patients' cancers may be effectively treated before interpersonal networks are disrupted. Yet for many cancer patients, especially those who are debilitated by their illness for a long period of time, none of these naturally occurring preventions may apply. These patients may benefit from psychological interventions which prevent or correct problems in their social relations, and from health care providers' awareness and understanding of these problems. The following sections discuss the implications of what has been presented here for intervention with patients and their family members, and offer some preliminary guidelines for the health care professional.

Potential Treatment Interventions for Patients and Family Members

One treatment suggested by the model is a family therapy program which makes cancer patients and their family members aware of the complicated social environment in which they may be trapped, and which encourages more open communication (Binger et al., 1969; Cohen, Goldenberg, & Goldenberg, 1977;

Olsen, 1970; Sheldon et al, 1970; Wellisch, Mosher, & Van Scoy, 1978). Cancer patients could learn that the rejection they receive from others is often independent of their own behavior, and family members could be taught that their feelings of anger and guilt toward the patient are normal under the circumstances. Both could be taught communication skills and strategies to combat specific problems.

A second implication of the model is that it might be useful to increase the cancer patient's access to others who have experienced cancer. Peer support groups of individuals who have experienced similarly disruptive events in their lives are growing rapidly across the country. There are now support groups for cancer patients, heart patients, stroke patients, multiple sclerosis patients, alcoholics, diabetics, widows, bereaved parents, rape victims and other victimized populations (Levy, 1976). There are many reasons why peer support groups might be helpful to patients with life-threatening illness. First, such groups provide an array of similar others from which to choose for comparison, and an appropriate setting for open communication. In such settings, people have an opportunity to share their feelings and problems with others. Second, they can exchange factual information about such things as where to get a good price and fit on a prosthesis, how to minimize nausea from chemotherapy, how to go about making out a will, and how to apply for disability benefits. They can also obtain advice and suggestions about how to cope with specific personal problems. In trying to make decisions about such issues as what to tell people at work or how much to tell one's children, patients can profit enormously from learning about the experiences of others who have dealt with these problems. Third, interacting with similar others should help the patient make an "accurate" attribution about the things happening to him or her. For example, by interacting with other cancer patients, it may become evident to the patient that the rejection or avoidance he or she experiences is a normal consequence of the disease, not a reflection of his or her own inadequacy and weakness. In addition to benefitting patients, such groups might be helpful for family members in many of the same ways.

Despite the sharp increase in peer support groups in the past few years, we are aware of no studies that have evaluated their effectiveness in helping victims cope with misfortune. Many specific questions about the value of interacting with similar others are worthy of attention. Under what conditions are cancer patients and others victimized by uncontrollable life events receptive to

interacting with similar others, and when do they prefer to avoid such contact (cf. McIntosh, 1977; Mitchell & Glicksman, 1977)? At the earliest stages of the disease, for example, people may have difficulty accepting their identity as cancer patients, and may therefore be unreceptive to interactions with "similar others." How do interactions with similar others differ from those with dissimilar others in terms of their content or their effect on the patient? How are patients affected by interactions with a person who is doing better or worse, either psychologically or physically, than they are? Do interactions with similarly afflicted others really alter a patient's attributions of causality about his or her responses to the illness? If so, is this helpful? Is it in fact more adaptive for patients to believe that others' avoidance stems from their disease and is therefore inevitable, than for them to believe there is something they can do about it?

Several reasons why patients might profit from interacting with one another have been suggested, but it is also possible that interaction could be stressful, or even harmful to patients. Comparing oneself to another person is not always adaptive (cf. Brickman & Bulman, 1977). Sanders and Kardinal (1977) have pointed out that patients often use others who are doing well as a yardstick to measure their own progress. Conceivably, this social comparison might be distressing if the patient does not "measure up" favorably. Direct contact with other patients may also make it difficult to employ certain psychological defenses. For example, a patient who is coping with fear of recurrence by assuming that he or she is cured may become very upset upon encountering a similar other who has had a recurrence. Finally, the attitude of the comparison person may be a critical determinant of the value of an interaction. A study by Carey (1974) has suggested that the opportunity to talk openly and honestly with another dying person facilitates effective coping only when the dying person faces death with peace and equanimity. Talking with a dying person who was unable to accept his or her approaching death was negatively associated with effective coping.

Kleiman et al. (1977) have discussed these and other major problems which may arise when cancer patients interact with other cancer patients. While we believe that contact with similar others is generally helpful, this treatment should be utilized with care until further research has been conducted. We would recommend, for example, that support groups or peer counseling be carefully supervised by trained professionals who can clarify misconceptions

that arise and deal with any problems that may develop. We also feel that attendance at such groups, or other kinds of exposure to similar others, should be strictly voluntary. Patients who would find such contact threatening should certainly feel free to decline participation in support groups or visitation programs.

Guidelines for the Health Care Professional

From the time of diagnosis through the duration of the patient's illness, the health care professional is in a unique position to intervene on the patient's behalf. Through an awareness of patient's needs for validation and support, and of the destructive pattern of feedback that they are likely to receive from those in their social environment, health care professionals can take specific actions to help prevent or correct interpersonal problems. At a minimum, they can avoid relating to the patient in ways that exacerbate these problems.

One step that the health care professional can take early in the patient's treatment is to provide some information about the sensations, feelings, and possibly emotions that are likely to accompany the disease or the treatment. As noted earlier, the literature has generally shown that information reduces the level of patient distress. Yet the available evidence suggests that such information is often not provided (cf. Bloom & Ross, Note 3; Mitchell & Glicksman, 1977; Peck & Boland, 1977). For example, both Mitchell and Glicksman (1977) and Peck and Boland (1977) have conducted interview studies with approximately 50 cancer patients undergoing radiation therapy. In the study by Mitchell and Glicksman, the majority of patients indicated that they had received no information whatsoever from the referring physician about the nature of the therapy they were to receive. These results were corroborated by Peck and Boland (1977), who concluded that patient beliefs were usually "inaccurate, pessimistic, and alarming" (p. 181).

Many physicians are reluctant to discuss the possibility of negative emotions or undesirable side effects with the patient even if the patient specifically requests this information. It is often believed that such discussions will increase the likelihood that the patient will experience the emotion or side effect in question. The interview study by Peck and Boland (1977), mentioned above, suggests that this is unlikely. Patients who had been informed about possible negative side effects of radiation appreciated this information, and praised their physicians for providing it. None of the patients in the study complained because the

physician had told him or her about a side effect that did not occur. However, patients who had not been warned about side effects that did occur were angry and disappointed with their physicians. Our experience in support groups has suggested that patients are often terrified by unexpected side effects, and believe them to be evidence of metastasis. Interestingly, Peck and Boland (1977) found that many patients assumed the worst about unexpected side effects, and had difficulty accepting their physicians' explanations after the side effects had occurred.

A second step that health care professionals can take at early stages of treatment is to inquire about the social support network that is currently available to the patient. The literature is strong and consistent in suggesting that patients who do not receive support from their family and friends have more difficulty in coping with their illness and are less likely to cooperate with treatment regimens (see Wortman & Silver, in press, and Cobb, 1976, for a more detailed discussion of this issue). Patients who lack social support may be in special need of time and attention from the health care staff. The health care professional can enhance the likelihood that family members will provide support for the patient by involving them in the patient's care. Family members who do not understand the nature of the disease or the medical procedures involved are not in a position to offer encouragement or support to the patient. A family member who is unaware of the side effects of chemotherapy, for example, may be annoyed rather than sympathetic with the patient's nausea and general tiredness.

Health care professionals can also help the patient by encouraging open communication, both in their own interactions with the patient and in patient interactions with family members. As noted earlier, available evidence suggests that the opportunity to discuss one's experience helps the patient come to an understanding of what is happening to him or her. Furthermore, misunderstandings and resentments can accumulate in settings where people are unable or unwilling to discuss their feelings about the disease (see, e.g., Glaser & Strauss, 1965). For example, a mother in our support group who was suffering from terminal bone cancer began drawing away from her children. Because she loved them so much, she wanted to prepare them for the time when she would be gone by forcing them to learn to take care of themselves and be independent. Needless to say, the children were unaware of her motives and were hurt and confused by this apparent lack of interest in them.

In an article discussing a therapy program for couples in which the woman has had a mastectomy, Witkin (1975) has identified a misunderstanding that is extremely common. According to Witkin (1975), many husbands assume that they should not have sex or indicate a desire for sex until their wife suggests it: "One husband stated, 'I didn't have sex with my wife for a long time because I felt she really didn't want it, what with the operation and her breast gone . . . I imagine I wouldn't feel like it after such an operation . . . ' In his fear of early intercourse, the husband may be genuinely concerned about his wife and want to do what's best for her. What happens is the reverse: the woman interprets his abstinence as confirming her worst fears, that he is disgusted, sees her as half a woman, can't stand looking at or caressing her, doesn't want her anymore" (p. 300).

In each of these examples, open discussion of the feelings behind some of the behaviors helped to alleviate the patients' and family members' distress. Of course, there may be limits to the general principle that open communication is helpful (cf. Schulz, 1978). Future research is needed to help distinguish the conditions under which full discussion of one's feelings is helpful from those in which it may be detrimental.

A final implication of this model for health care professionals is that it may help to explain why they often have ambivalent feelings toward their patients—patients that they are supposedly trying to help. Past research has suggested that even a single encounter with a victim can be a powerfully distressing experience, and can result in blame and derogation of the victim. Since health care professionals frequently have repeated and intense interactions with people who are suffering, it is not surprising that ambivalent and negative feelings should develop.

Maslach (1976) has studied the phenomenon of "burnout" among professionals working in the helping fields. She has found that it is extremely common for such workers to come to think of their patients or clients in derogatory terms, and even come to believe that the clients deserve any problems they have. According to Maslach (1976), "They lose all concern, all emotional feeling, for the persons they work with and come to treat them in detached or even dehumanized ways" (p. 16). Interestingly, Maslach and her colleagues (Maslach, 1976; Pines & Maslach, 1978) have found that many health care professionals believe that their negative reaction to their patients is a reflection of some personal failing. Maslach's (1976) research has suggested

that burnout rates are lower for professionals who can choose to minimize contact with patients or clients when the stress becomes too much for them, and for professionals "who actively express, analyze, and share their personal feelings with their colleagues" (p. 22). By sharing their emotional reactions with others, they can learn that these feelings are a normal consequence of dealing with victimized individuals, and can receive constructive feedback on how to cope with their distress.

CONCLUDING COMMENTS

What are the overall implications of this model? Because research on the interactional dynamics of cancer is still in its infancy, it is not possible to offer specific guidelines to be followed in one's relationship with cancer patients. However, we believe that there is great potential value in understanding the patient's need for clarification and support, and in recognizing and understanding one's own feelings, beliefs and behaviors with regard to the patient. Above all, it is important to understand that the cancer patient and those around him or her form an interactional system where each person's behavior affects the other. As Coyne (1976a) has said about the depressed, the patient's behaviors are "interwoven and concatenated with a corresponding pattern in the response of others" (p. 186).

Social psychology has a rich history of theory and research on social comparison, affiliation, and attribution that is rarely applied to the health care field. The model presented here is a direct application of some social psychological principles to the interactional system of the cancer patient. Because such applications are new to the health field, there is a scarcity of relevant data on these topics. Consequently, much of the present reasoning is in need of further documentation. Nonetheless, we believe that the possibility of beginning collaborative efforts between social psychologists and health care professionals on these issues is exciting and potentially beneficial to both groups.

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