THE PATTERN OF ADJUSTMENT AMONG CANCER PATIENTS

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Abstract: Cancer begins when cells in a part of the body start to grow out of control. Human beings have had cancer throughout recorded history. It is estimated that 35,000 new cancer cases occur in Kerala in one year. Among males 50% of cancers in the mouth, throat and lungs are caused by Tobacco and alcohol habits. Among women tobacco related cancers are 15%. The present study attempted to study the adjustment pattern of persons with cancer and persons without cancer. In this study, purposive random sampling method was adopted to select the sample. The sample consisted of 60 subjects, 30 subjects with cancer, and 30 subjects without cancer. The tool used was adapted version of Bell Adjustment Inventory done by Raju and Sananda Raj in 1990. The data was analyzed using SPSS. 't' test was used for comparing persons with cancer and persons without cancer. The result of the present study shows that, there was significant difference in the adjustment pattern between cancer patients and those who are not affected with cancer.

*Key Terms: Adjustment, Cancer***.**

INTRODUCTION

Non-communicable diseases including cancer are emerging as a major public health problem in India. These diseases are lifestyle related, have a long latent period and needs specialized infrastructure and human resource for treatment. India still has a high burden of preventable communicable diseases and will offer competition for the resource allocation. The origin of the word cancer is credited to the Greek physician Hippocrates (460-370 BC), who is considered the "Father of Medicine." Hippocrates used the terms *carcinos* and *carcinoma* to describe non-ulcer forming and ulcer-forming tumors. In Greek, these words refer to a crab, most likely applied to the disease because the finger-like spreading projections from a cancer called to mind the shape of a crab. The Roman physician, Celsus (28-50 BC), later translated the Greek term into *cancer*, the Latin word for crab. Galen (130-200 AD), another Roman physician, used the word *oncos* (Greek for swelling) to describe tumors. Although the crab analogy of Hippocrates and Celsus is still used to describe malignant tumors, Galen's term is now used as a part of the name for cancer specialists — oncologists. The 19th century saw the birth of scientific oncology with use of the modern microscope in studying diseased tissues. Rudolf Virchow, often called the founder of cellular pathology, provided the scientific basis for the modern pathologic study of cancer. Our body is composed of many millions of tiny cells, each a self-contained living unit. Normally, each cell coordinates with the others that compose tissues

and organs of our body. One way that this coordination occurs is reflected in how our cells reproduce themselves. Normal cells in the body grow and divide for a period of time and then stop growing and dividing. Thereafter, they only reproduce themselves as necessary to replace defective or dying cells. Cancer occurs when this cellular reproduction process goes out of control. In other words, cancer is a disease characterized by uncontrolled, uncoordinated and undesirable cell division. Unlike normal cells, cancer cells continue to grow and divide for their whole lives, replicating into more and more harmful cells. The abnormal growth and division observed in cancer cells is caused by damage in these cells' DNA (genetic material inside cells that determines cellular characteristics and functioning). There are a variety of ways that cellular DNA can become damaged and defective. For example, environmental factors (such as exposure to tobacco smoke) can initiate a chain of events that results in cellular DNA defects that lead to cancer. Alternatively, defective DNA can be inherited from parents. As cancer cells divide and replicate themselves, they often form into a clump of cancer cells known as a tumor. Tumors cause many of the symptoms of cancer by pressuring, crushing and destroying surrounding non-cancerous cells and tissues. Tumors come in two forms; benign and malignant. Benign tumors are not cancerous, thus they do not grow and spread to the extent of cancerous tumors. Benign tumors are usually not life threatening. Malignant tumors, on the other hand, grow and spread to other areas of the body. The process whereby cancer cells travel from the initial tumor site to other parts of the body is known as metastasis.

The causes of cancer are not fully understood, but years of research have brought to light risk factors that increase people's chances of getting particular types of cancer. Some of these risk factors are inevitable, while others can be avoided by choosing to live a healthy lifestyle. For example, smoking cigarettes is an avoidable risk factor. Changing your lifestyle to get rid of unhealthy choices such as smoking can be difficult to accomplish (tobacco is an addictive drug and stopping smoking means beating that addiction), but the rewards are real. Stopping smoking and similar healthy lifestyle changes will not insure that you never get cancer, but they will reduce your cancer risk.

Though cancer is often thought of as a single disease there are in fact many different cancer variations. Each different type of cancer has a different set of risk factors, different rates of progression, different treatment options, and a different prognosis. Further, the subtypes of cancer get classified and named based on the area of the body where they are originally observed. The most common types of cancer are breast cancer, colorectal cancer, lung cancer, prostate cancer, and skin cancers.

Some of the cancer symptoms are manifest outwardly, and are relatively easy to notice and identify (such as a lump in the breast for breast cancer, or blood in the stool corresponding to colorectal cancer). Other symptoms are observable, but harder to decipher. For instance, two of the major symptoms for lung cancer are a bronchitis-like deep cough and excessive shortness of breath. Few people would assume these symptoms were serious and fewer would associate them with cancer. Still other forms of cancer produce no observable

symptoms until they are at a very advanced (and therefore hard to treat) stage. Specific symptom detail for cancer subtypes is provided in our cancer subtype documents.

A physician who suspects a patient may have a specific form of cancer will perform a series of tests and procedures to diagnose (or rule-out) a cancer. Commonly, doctors will collect a sample of tissue or fluid from the area believed to contain a cancerous tumor so that it may be analyzed in the laboratory under a microscope. This collection and observation procedure is known as a biopsy. Often, performing a biopsy and analyzing the resulting samples is the only way that doctors can accurately determine a diagnosis of cancer.

Following a positive identification of cancer, doctors will try to establish the stage of the cancer. Cancers are ranked into stages depending on the specific characteristics that they possess; stages correspond with severity. Determining the stage of a given cancer helps doctors to make treatment recommendations, to form a likely outcome scenario for what will happen to the patient (prognosis), and to communicate effectively with other doctors. There are multiple staging scales in use. One of the most common ranks cancers into five progressively more severe stages: 0, I, II, III, and IV. Stage 0 cancer is cancer that is just beginning, involving just a few cells. Stages I, II, III, and IV represent progressively more advanced cancers, characterized by larger tumor sizes, more tumors, the aggressiveness with which the cancer grows and spreads, and the extent to which the cancer has spread to infect adjacent tissues and body organs. Another popular staging system is known as the TNM system, a three dimensional rating of cancer extensiveness. Using the TNM system, doctors rate the cancers they find on each of three scales, where T stands for tumor size, N stands for lymph node involvement, and M stands for metastasis (the degree to which cancer has spread beyond its original locations). Larger scores on each of the three scales indicate more advanced cancer. For example, a large tumor that has not spread to other body parts might be rated T3, N0, M0, while a smaller but more aggressive cancer might be rated T2, N2, M1 suggesting a medium sized tumor that has spread to local lymph nodes and has just gotten started in a new organ location.

Doctors prescribe cancer treatment regimens based on a variety of factors specific to patients' individual circumstance. These factors often include the cancer's stage (type, location, and size of the cancer being treated), as well as patients' age, medical history, and overall health. The doctor may also ask patients to specify their treatment preferences before determining an optimal treatment plan. So long as their condition does not require emergency intervention, patients should feel free to ask questions about various treatment options so as to become comfortable with the plan they will ultimately follow. Each form of cancer is different and calls for a different set of treatment approaches. This being true, there are two common approaches used to treat almost all types of cancer. These two treatments are chemotherapy and radiation therapy.

One of the most critical impact of concern is the acute psychological distress as the patient confronts the implications of cancer: possible death, dependence on others disability, disfiguring changes in the body and loss of function (Ledersberg et al.1993). Cancer like any other serious and chronic disease stands as a symbol for the unknown and dangerous, for suffering and pain, for guilt and shame, for isolation and

abandonment, for chaos and anxiety. It is often seen as a personal disaster, a crisis for both the patient and the family (Bolund, 1990). It is a crisis that evokes psychological responses from those affected. The initial response, according to Lederberg (1993) of an individual diagnosed having cancer is that of disbelief, a feeling of numbness. The next stage is that of anxiety and depression. The patient is pre-occupied with the implications of the illness, thoughts about the future and sense of helplessness. Attention and concentration are impaired, sleeping and eating patterns are disrupted. The two distinct phases involved are the shock phase and the reaction phase. The next phase is that of working through, where the patient with his/her coping skills tries to deal with the crisis. Chaturvedi et al. (1994). Lederberg (1993), Holland (1989), have studied psychiatric morbidity in cancer patients and it is seen that anxiety and depression are the commonest psychiatric problems seen among cancer patients. Cancer patients have the same frequency of depression as other medically ill patients, when the level and severity of physical illness are controlled for (Lederberg, 1993). Anxiety appears in cancer in all stages of the disease right from diagnosis, relapse and treatment failure, usually mixed with depression. Patients feel persistently on the edge, tense and are unable to relax. Panic attacks, irritability and poor concentration and autonomic symptoms are also present (Holland, 1990).

The development of life-threatening and chronic disease like cancer has, apart from psychological consequences, profound social consequences also for both patients and those close to them. The onset of the disease tells upon various aspects of the patient's life such as the activities of daily living, domestic life, social environments, working conditions, and general outlook on life itself. One of the major consequences of cancer is the effect it has on the family and its structure. The burden of the care of the cancer patient, whether at home or at hospitals falls mainly on the family. More often, there is a loss of family income on the part of a family member due to his or her own illness or to having to limit working hours because of the illness of another family member. This creates an impossible burden for many families. The family is part of the individual and individual is the part of the family. Therefore any illness in one member of the family is most felt by the family. One of the direct effects of illness in the family is the change of roles within the family unit, which may be significant and sometimes permanent. Role strain also sets in the family. The obligations that the role changes bring in are sometimes over-demanding for most people. They try to combat these strains using certain strategies aiming to reduce the effect of this phenomenon. The sick - role of the patient in the family is inevitable in most cases.

Adjustment and Cancer Patients

Adjustment or psychosocial adaptation to cancer has been defined as an ongoing process in which the individual patient tries to manage emotional distress, solve specific cancer-related problems, and gain mastery or control over cancer-related life events. Adjustment to cancer is not a unitary, single event but rather a series of ongoing coping responses to the multiple tasks associated with living with cancer. Patients are faced with multiple challenges that vary with the clinical course of the disease. Common periods of crisis and significant challenge include diagnosis, treatment (surgery, radiation, and chemotherapy), post treatment and remission,

recurrence and palliative care and finally survivorship. Each of these events has certain coping tasks, particular existential questions, many common emotional responses, and specific problems. Normal or successful adjustment is indicated in patients who are able to minimize disruptions to life roles, regulate emotional distress, and remain actively involved in aspects of life that continue to hold meaning and importance.

Need and Significance of the present study

Professionals in health care have become increasingly concerned of the psychosocial aspects of health and illness. Health practitioners firmly believe in the interaction between the psychic and organic components of illness. The physiological and psychosocial problems among cancer patients is a matter of great concern to health care professionals, psychologists and social workers. The problem of cancer has to be viewed from psychosocial angle, in addition to pathological and pharmaceutical areas. This has warranted the attention of professionals like clinical social workers, who basically deal with the psychosocial and economic aspects of various illness groups. The study, would primarily contribute to a better understanding of the psychosocial factors that govern the day-to-day living of cancer patients and its impact on his/ her family. The findings of the study could be of immense value to therapists in developing and strengthening innovative psychosocial models of treatment which would benefit the cancer patients and their families. A study like this can also serve as an eye-opener to the concerned in their bid to appreciate the psychosocial problems of cancer patients in depth and to take appropriate measures in their treatment package.

Statement of the problem

To study the adjustment level among cancer patients**.**

Definition of Key Terms

Adjustment- According to Sarason and Sarason (1993), "adjustment implies mastery over one's environment and being at peace with oneself". It refers to the ability to satisfy the demands of our surroundings as well as our need, so, it is a healthy balance between what we want and what society demands.

In the present study, adjustment means, the total scores obtained for all the items in the Adjustment inventory developed by Raju and Raj (1990).

Cancer- Cancer is the uncontrolled growth and spread of cells that can affect almost any part of the body (WHO, 2014).

In the present study, cancer patients were taken as the participants.

Objective

The objectives of the present study are:

1) To find out the significant difference in the family adjustment between persons with cancer and without cancer.

2) To find out the significant difference in the health adjustment between persons with cancer and without cancer.

3) To find out the significant difference in the social adjustment between persons with cancer and without cancer.

4) To find out the significant difference in the emotional adjustment between persons with cancer and without cancer.

5) To find out the significant difference in the total adjustment between persons with cancer and without cancer.

Hypotheses

The hypotheses of the present study are:

1. There will be significant difference in the family adjustment between persons with cancer and without cancer.

2. There will be significant difference in the health adjustment between persons with cancer and without cancer.

3. There will be significant difference in the social adjustment between persons with cancer and without cancer.

4. There will be significant difference in the emotional adjustment between persons with cancer and without cancer.

5. There will be significant difference in the total adjustment between persons with cancer and without cancer.

METHOD

Participants

The sample for the present study consisted of 60 samples, 30 subjects with cancer, and 30 subjects without cancer of age ranges from 30 to 60. The sample was randomly selected from Ernakulam district. The persons without cancer is also selected randomly from different areas of Ernakulam district matching correspondingly to the sociodemographic variables of cancer patients.

Instruments

1. **An Adjustment Inventory-** An adjustment inventory was originally developed by Bell, and published by Stanford University Press. It was adapted to Malayalam (regional language in the state of Kerala) by Nair in 1970. The Adjustment Inventory used for the present study is an adapted version of Bell Adjustment Inventory done by Raju and Sananda Raj in 1990. The test is primarily meant for adults and has five sections. The occupational adjustment section will be of value only with persons who are working for an employer at the time they take the test. Unemployed individuals and house wives should be scored only for family, health, social and emotional adjustment. For the present study the above stated four measures of adjustment has been used. Here occupational section was not used because the sample selected includes unemployed also. The test is found to have adequate reliability and validity.

2. **Personal Data Sheet**- A personal data sheet was prepared for use in the present study. It consists of 10 items and they deal exclusively with personal information such as the subjects name, age, sex, religion, education, job, marital status (whether married or unmarried or divorcee), place of residence (whether rural or urban), present place of stay (whether home or hostel or rehabilitation centre) and monthly family income.

Procedure

The data for the present study was collected from different patients who have undergoing cancer treatment. The investigator approaches them in personal for the purpose of data collection. A preliminary introduction was given to them regarding the relevance of the present study. After having established rapport with them and having emphasized the need for their truthful responses, the questionnaires were distributed. The respondents were also ensured of the confidentiality of their responses. They were first asked to fill in their personal details in the data sheet that was provided. Next they were asked to read the instructions very carefully. After everybody finished reading the instructions, they were asked to ask questions and clear any doubts that have raised in their minds. They were then asked to start answering the questionnaire. After completion of the test, they were asked to hand over the questionnaires and the personal data sheet. Similarly, datas from the control group were also collected using the same procedure.

Results and Discussion

Table 1

Means and standard deviation of the scores in family adjustment among persons with cancer and without cancer.

Variable	Categories	N	Means	Std. Deviation	t-value
Family Adjustment	Person with Cancer	30	37.33	3.79	
	Person without Cancer	30	38.43	3.86	1.11

Table 1 shows the means, standard deviations and t-value corresponding to the categories with respect to their level of adjustment with family. From the results it can be seen that there is no significant difference between the cancer patients and the persons without cancer. The persons without cancer are found to have high level of family adjustment (M=38.43) than the cancer patients (M=37.33). But the results are not significant. The low score for the cancer patients may be because they may not have a harmonious relation with family members, physical facilities available for them, or may not have any freedom in their daily activities etc.

Table 2

Means and standard deviation of the scores in health adjustment among persons with cancer and without cancer.

Variable	Categories	N	Means	Std. Deviation	t-value
Health Adjustment	Person with Cancer	30	28.20	3.46	14.513**
	Person without Cancer	30	39.93	2.77	

** Significant at 0.01 level (2-tailed)

Table 2 shows the means, standard deviations and t-value corresponding to the categories with respect to their level of health adjustment. From the results it can be seen that there is significant difference between the cancer patients and the persons without cancer on health adjustment. The persons without cancer are found to have high level of health adjustment (M=39.93) than the cancer patients (M=28.20). This may be because the cancer patients may not be able to resist diseased conditions and any permanent physical ailment etc. They might be more worried about their health and future.

Table 3

Means and standard deviation of the scores in social adjustment among persons with cancer and without cancer.

Variable	Categories	N	Means	Std. Deviation	t-value
Social Adjustment	Person with Cancer	30	31.50	4.65	1.152
	Person without Cancer	30	32.73	3.57	

Table 3 shows the means, standard deviations and t-value corresponding to the categories, with respect to their level of social adjustment. From the results it can be seen that there is no significant difference between the cancer patients and the persons without cancer. The persons without cancer are found to have high level of social adjustment (M=32.73) than the cancer patients (M=31.50). But the results are not significant. Cancer patients may have few social relationships; their disease may harm their social status, and leadership qualities etc. Many cancer survivors may tend to isolate from the society for the fear of rejection or they are actually isolated by their family and friends due to the continued social stigma of cancer.

Table 4

Means and standard deviation of the scores in emotional adjustment among persons with cancer and without cancer.

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Variable	Categories	N	Means	Std. Deviation	t-value
Emotional Adjustment	Person with Cancer	30	25.90	3.30	13.428**
	Person without Cancer	30	38.40	3.88	

Significant at 0.01 level (2-tailed)

Table 4 shows the means, standard deviations and t-value corresponding to the categories, with respect to their level of emotional adjustment. From the results it can be seen that there is significant difference between the cancer patients and the persons without cancer on emotional adjustment at 0.01 level. The persons without cancer are found to have high level of emotional adjustment (M=38.40) than the cancer patients (M=25.90). This may be because cancer people, due to their awareness of disease are more sensitive, and may have more tendencies to fear, obsession, worries, anxiety, depression etc.

Table 5

Means and standard deviation of the scores in total adjustment among persons with cancer and without cancer.

Variable	Categories	N	Means	Std. Deviation	t-value
Total Adjustment	Person with Cancer	30	122.93	9.83	12.18**
	Person without Cancer	30	149.50	6.78	

** Significant at 0.01 level (2-tailed)

Table 5 shows the means, standard deviations and t-value corresponding to the categories, i.e., cancer patients and the persons without cancer with respect to their level of total adjustment. From the results it can be seen that there is significant difference between the cancer patients and the persons without cancer in total adjustment at 0.01 level. The persons without cancer are found to have high level of total adjustment

(M=149.50) than the cancer patients (M=122.93). This may be because it is too difficult for the cancer patients to manage their emotional distress, solve specific cancer-related problems, and gain mastery or control over cancer-related life events. Adjustment to cancer is not a unitary, single event but rather a series of ongoing coping responses to the multiple tasks associated with living with cancer. Patients may be faced with multiple challenges that vary with the clinical course of the disease.

CONCLUSION

The present research has focused on the adjustment and self esteem of cancer patients. The findings of the study are of use to the health professionals in the sense that they can apply them for improving the physical health, mental health and the social relationships of those affected with cancer. The physiological and psychosocial problems among cancer patients are a matter of great concern. The study is beneficial for counselors to guide the cancer patients in developing good mental health and self-esteem, so that it may improve their quality of life, reduce their depression, anxiety, stress and stress related problems.

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