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Coping with Cancer, Quality of Life, and Return-to-Work

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Abstract

Coping strategies for people with cancer and chronic illness are examined in a comprehensive literature review, which includes a variety of cancer diagnoses and stages. Strategies a person would use to cope with cancer, i.e., physical, psychosocial, emotional, spiritual, and vocational functioning are identified. A person's ability to use the identified coping strategies, during and after a cancer diagnosis, directly impacts one's quality of life. Based on this review, implications for rehabilitation counselors, case managers, disability specialists, as well as implications for future research are discussed.

Advances in medical research, growth in technology, and discoveries in pharmacology have led to an increased life expectancy and people are living longer lives than in years past. The National Commission on Chronic Illness, established in 1949, defines chronic illness as "all impairments or deviations from normal that have one of more of the following characteristics: are permanent, leave residual disability; are caused by non-reversible pathological alteration; require special training of the patient rehabilitation; or may be expected to require long period of supervision, observation or care" (Sidell, 1997, p. 2). Although there are many definitions of chronic illness, it is considered to be any health condition that lasts for an extended period of time. Thus, cancer, in all its forms, can be considered a chronic illness, one that affects millions of people and their families each year (Hart, 2007).

The National Cancer Institute reports that nearly 45% of men and nearly 39% of women are at risk for developing cancer in their lifetime; moreover, cancer is the second leading cause of death in the United States (Franks & Roesch, 2006). Furthermore, it is widely acknowledged that a growing number of people with cancer are surviving and living longer lives. It is important then to consider the physical, emotional, psychological, and social health of people with cancer as they are coping and adjusting to the illness.

Coping with Cancer

Each individual responds to illness in their own way with varying coping styles and patterns. Individuals with cancer require a wide range of coping options to deal with changing functional abilities, medical implications, interventions, and psychosocial reactions (Livneh, 2000). Earlier investigations of coping with cancer centered on recording the regularity of use and meaning of psychological defense mechanisms (e.g., denial, projection, suppression, and displacement) in adjusting to the illness (Livneh, 2000). Freud was the first to use these in his development of psychoanalytic theory. Freud's ego-defense mechanisms are intra-psychic processes that operate to protect a person from threatening and anxiety-producing thoughts, feelings, and beliefs (Corey, 2009).

Illnesses which are chronic, including cancer, can have the ability to place considerable stress and anxiety on a person. Stresses and strains with chronic illnesses like cancer may be financial (e.g., inability to work), social (e.g., withdrawal due to illness), or role related (e.g., family taking care of father who is chronically ill) (Dobbie & Mellor, 2008). Thus, cancer can have a dramatic affect on a person, and has the ability to encompass all areas of their lives. A person's ability to effectively cope with a cancer diagnosis directly relates to their quality of life (Boehmer, Luszczynska, & Schwarzer, 2007).

Quality of Life

Quality of life is an important factor for a person living with cancer. Quality of life is a "multidimensional concept encompassing an individual's perceived physical, psychosocial, emotional, sexual, spiritual, and vocational functioning" (Dunn et al., 2006, p. 21). This is a significant justification for exploring the perceptions patients have following a cancer diagnosis. Quality of life of cancer patients is affected by a number of factors, ranging from diagnosis, stage of disease, the kind of treatment a person receives, the patient's performance status, physical exercise, depression, and spiritual beliefs (Kreitler, Peleg, & Ehrenfeld, 2006). Quality of life is directly connected with the patient's ability to use coping strategies in relation to the illness.

Quality of life can be looked at in two components: the ability to perform everyday activities that reflect physical, psychological, and psychosocial well-being; and patient satisfaction with levels of functioning and control of the disease (Avis et al., 2005). Consequently, several domains further divide quality of life. These may include sexual functioning, negative feelings, cognitive problems, pain, energy, family distress, appearance, and disease-recurrence (Avis et al., 2005). Consequently, many types of coping methods exist with most processes involving the constant changing of thoughts and behaviors in an effort to manage these specific external or internal demands that are perceived as challenging or exceeding the resources of the person (Deimling et al., 2006).

Stress Responses

One of those internal coping methods involves stress response. Research by Lazarus and Folkman (as cited in Deimling et al., 2006, p. 145) on stress response addresses three distinct progressions: (a) perceiving a threat, (b) forming a response to the threat and (c) coping responses. Pikler and Brown (2010) reported that a typical response when diagnosed with chronic illness includes a period of initial shock followed by either a positive or negative appraisal of the stressor, which in this case is cancer. Lazarus and Folkman identified patterns of coping among cancer patients following this primary appraisal of the illness. These patterns include: distancing, seeking or using social support, and focusing on the positive (Deimling et al., 2006).

Distancing and Denial

Distancing and other disengagement strategies normally refer to mostly negative approaches to coping with stress and crisis. These include: denial (e.g., selective ignoring, threat minimization, and suppression), wishful thinking or fantasy, problem avoidance or escape, self-criticism or self-blame, social withdrawal, substance or chemical abuse or more generally behavioral disengagement (Livneh, 2000). The first stage of Kubler-Ross' stages of death and dying refers to denial and isolation. She said that denial was an early response to grief, which gradually diminishes on the person's journey toward acceptance (Diessner, 2008).

Denial is an ego defense mechanism which involves the minimization and even complete refusal of the chronicity, extent, and future implications associated with the condition (Dell Orto & Power, 2007). Freud and Kubler-Ross alike view denial as healthy when it serves a protective function in the short term, but if prolonged, it could result in complicated or pathological grief (Telford, Kralik, & Koch, 2005).

Social Supports

Seeking or using social supports can come in many different forms for a person living with cancer. Social support usually refers to the functions performed for a person by their non-professional significant others, such as family members, friends, and other acquaintances including coworkers or church members (Hudek-Knezevic, Kardum, & Pahljina, 2002). Supportive interpersonal relationships provide an emotional support for people with chronic illness including cancer. Other types of social support include instrumental (e.g., assisting with a problem) and informational (e.g., advice) (Morgan, 2008). The stressful effects of all types of cancer reach beyond the patient themselves, and into the lives of family members and other close contacts.

The type of relationship a person with cancer has with his/her spouse is important in the recovery and coping process. Partners play a vital role is the patient's recovery, this is because they can instill optimistic self-beliefs and encourage the patient to cope with discomfort and relapses (McLean & Jones, 2007). Partners can also play a key function in seeking out information concerning their spouse's diagnosis, as well as helping with the decision making process. Many couples can draw on their bond and develop confidence in their ability to deal with the issues associated with the disease (e.g., dealing with the unknown, the threat of loss, the uncertainties and changes) and to turn this experience of suffering into a meaningful life event (Pickard, Dumont, Gagnon, & Lessard, 2005).

The American Cancer Society estimates that three out of four families with be affected by cancer at some point during the course of a lifetime, and it is important to realize that just as the family has a significant role in providing support for the patient, the entire family is affected physically, emotionally, socially, and psychologically when a family member has cancer (Mitschke, 2008). Again, it is of note that family members may provide the primary means of support for a person coping with cancer. Research suggests that sufficient rest, support, and disclosure of information related to a cancer diagnosis are important concepts of family-centered coping methods (Mitschke, 2008). Furthermore, families should be involved in the technical aspects of coping with support continuing after discharge from the hospital, clinic, or oncology service (Riechers, 2004).

Social support for many people with cancer may come in the form of religion or spirituality. Religious practices such as prayer and meditation can help improve a sense of control over stressful events by "helping individuals achieve a personal relationship with a higher entity that offers strength and support to cope with their illness, and also provides a sense of purpose and meaning for seemingly incomprehensible events or chronic adversity" (Tarakeshwar et al., 2006, p. 647). Religious beliefs can help people with cancer understand and potentially accept the experience of death and dying. This type of acceptance and recognition of death, through religion, can improve a patient's quality of life. Attending religious services can provide a person with cancer additional social support, and perhaps decrease feelings of withdrawal and isolation from the community. Spirituality is a broader concept than that of religion. Spirituality is a quality that goes beyond religious affiliation that provides inspirations, meaning, and purpose, even in those who do not believe in any specific

higher power (Baldacchino & Draper, 2001). For those who do not wish formal affiliations, spirituality can provide a sense of comfort.

Resiliency

Lazarus and Folkman (as cited in Dunkel-Schetter, Feinstein, Taylor, & Falke, 1992) defined coping as cognitive and behavioral efforts to manage demands appraised as taxing or exceeding resources. One such effort is focusing on the positive. Positive emotions amidst negative events are important elements in the psychological resilience of, and coping by, people with cancer (Stam, Grootenhuis, Caron, & Last, 2006). Furthermore, three types of coping relating to positive affect have been identified: positive appraisal, goal-directed/problem-focused work, and resilience (Collins, 2007). The 'resilience construct' is a framework that seeks to explain why many individuals, regardless of the presence of a variety of psychosocial risk factors in their lives, are able to adopt resourceful techniques which have the effect of constricting negative and social cognitive experiences (McMurray, Connolly, Preston-Shoot, & Wigley, 2008). Five resiliency factors have been identified: personal competence, social competence, personal structure, family coherence, socioeconomic status (Friborg, Barlaug, Martinussen, Rosenvinge, & Hjemdal, 2005). Recent research (de Boer et al., 2008; Grunfeld, Rixon, Eaton, & Cooper, 2008) has shown that resiliency and focusing on the positive are key components in returning to work after a cancer diagnosis.

Work & Employment

Work and employment are important factors for an individual's sense of self and provides a much needed social connection, and returning to work is a viable coping option for a person with cancer. Work can also provide a distraction, and can enable a person with cancer to regain a sense of normalcy and control (Kennedy, Haslam, Munir, & Pryce, 2007). Returning to work, if possible, may improve a patient's quality life in an effort towards recovery.

Return-to-Work

With advances in early detection, treatment, and management of side effects, the life expectancy of people with many cancers is on the incline; moreover, with the increase in functional capacity, there is a greater need to focus on work outcomes as an important component of quality of life in cancer patients and survivors (Main, Nowels, Cavender, Etschmaier, & Steiner, 2005). Many factors may contribute to a person with cancer returning to work. Person (e.g., age), disease (e.g., stage of cancer, treatment methods), and work related (e.g., physical workload) factors are associated with returning to work (Sanchez, Richardson, & Mason, 2004).

A large proportion of younger and middle-aged persons will be part of the work force at the time of their cancer diagnosis, for this group, return-to-work is an important aspect of social reintegration (Spelten, Sprangers, & Verbeek, 2002). Working is a part of everyday-life for people with or without cancer or chronic illness. Work creates a structure for a person to live their life around. It is only when the individual is unable to work that the meaning of work and its pervasive incorporation in our lives becomes visible, breaking the natural order of everyday-life; moreover, work has moral connotations and is considered a duty of the individual in relation to society (Rasmussen & Elverdam, 2008).

Conclusions

How well one copes or adjusts to the stress and emotional response related to a cancer diagnosis, can have a positive impact on one's quality of life. Psychological coping techniques

have shown to improve patients' quality of life in response to a cancer diagnosis. Individuals respond to illness in their own way, with diverse coping styles and patterns. Furthermore, individuals with cancer require a wide range of coping options to deal with changing functional abilities, medical implications, interventions, psychosocial reactions, and monetary implications including return-to-work issues (Livneh, 2000). These coping strategies may be distancing or denial, the use of social supports, focusing on the positive (resiliency), and returning to work.

Implications for Rehabilitation Professionals

Implications for rehabilitation counselors, case managers, and disability specialists are vast when providing or managing case services for people with cancer and other forms of chronic illness. It is important for these rehabilitation professionals to treat a client holistically and personalize their client's services, taking into account all aspects of a consumer's life. With the increase in the amount of people surviving cancer and living longer after the course of the condition, effective counselors and case managers should be aware of the many quality of life domains which encompass a diagnosis. By doing this, rehabilitation counselors and case managers can better serve their clients in identifying and providing the supports systems which are available to them. Within this context, return-to-work may be viewed as a contributor to a cancer survivor's overall quality of life.

Future research focusing on the relationship of coping with cancer or long term illness, quality of life, and return-to-work, is needed in order to identify cancer specific quality of life indicators, such as feelings about work, disease factors, effects of cancer treatment, and so forth. Researchers may wish to codify these domains for development of specific screening tools rehabilitation professionals may use to increase a cancer survivor's readiness to return-to-work. Given the growing numbers of surviving with cancer and chronic illness, such efforts should support the growing need for evidence-based practice in the health care field.

About the Author

Paul J. Bourgeois, BS, CPhT, is a second year graduate teaching fellow at Springfield College where he is pursuing a MS in Rehabilitation Counseling & Services. This paper was adapted from a course assignment, submitted and subsequently selected to be orally presented at the 2010 Case Management/Disability Management Conference held in Scottsdale, Arizona this past February. Currently, Mr. Bourgeois sits on the IARP New England Board of Directors as the graduate student representative for the Chapter.

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