1994

Measuring codependency in breast cancer survivors

Lynda M. Ciano
San Jose State University

Follow this and additional works at: https://scholarworks.sjsu.edu/etd_theses

Recommended Citation

Ciano, Lynda M., "Measuring codependency in breast cancer survivors" (1994). *Master's Theses*. 899.
DOI: <https://doi.org/10.31979/etd.vvbp-9rba>
https://scholarworks.sjsu.edu/etd_theses/899

This Thesis is brought to you for free and open access by the Master's Theses and Graduate Research at SJSU ScholarWorks. It has been accepted for inclusion in Master's Theses by an authorized administrator of SJSU ScholarWorks. For more information, please contact scholarworks@sjsu.edu.

INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

UMI

A Bell & Howell Information Company
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
313/761-4700 800/521-0600

MEASURING CODEPENDENCY IN BREAST CANCER SURVIVORS

A Thesis

Presented to

the Faculty of the Department of Psychology

San Jose State University

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

by

Lynda M. Ciano

December, 1994

UMI Number: 1361157

UMI Microform Edition 1361157
Copyright 1995, by UMI Company. All rights reserved.

This microform edition is protected against unauthorized
copying under Title 17, United States Code.

UMI

300 North Zeeb Road
Ann Arbor, MI 48103

© 1994

Lynda M. Ciano

ALL RIGHTS RESERVED

APPROVED FOR THE DEPARTMENT OF PSYCHOLOGY

Gregory Feist, Ph. D. - Chairperson

Lynda Heiden, Ph. D. - Committee Member

Robert Witte, Ph. D. - Committee Member

Mary Ann Tyson, Ph. D. - Committee Member

APPROVED FOR THE UNIVERSITY

Serena H. Stanford

ABSTRACT

MEASURING CODEPENDENCY IN BREAST CANCER SURVIVORS

by Lynda M. Ciano

No research exists on the relationship between the cancer-prone and the codependent personalities, which appear to be two very similar syndromes. An established codependency assessment tool, the Spann-Fischer Codependency Scale (SFCDS) was administered to a group of 56 breast cancer survivors and 56 women who have not had cancer in an effort to determine whether the survivors score higher on this measure of codependency than the control group. Hypothesis one, which was that there would be a difference between the cancer and no cancer groups on the SFCDS was not supported. However, when the woman's self-report on ability to express anger was introduced as a covariate to breast cancer history, there was a significant difference on the SFCDS scores between groups, suggesting that anger moderates the relationship between codependency and cancer in some way. Hypothesis two, which was that women who have had breast cancer would report more difficulty expressing anger than women who have not had breast cancer, was not supported. By understanding the relationship between codependency and cancer, those women at risk for cancer may become targeted for intervention.

ACKNOWLEDGMENTS

I would like to acknowledge the work of my committee members. Dr. Feist read innumerable rewrites and knows my work as well as I do. Dr. Heiden lent her vast knowledge of the subject area. Dr. Tyson provided an excellent critical eye with her view on the future and potential input from peers. And Dr. Witte helped me to see what the pages of statistics meant.

I would also like to acknowledge Dr. Hicks for his untiring efforts to focus me on the purpose for this study. He gave me a firm basis on which to build.

Also, I would like to thank the College of Social Sciences for the foundation grant that covered the cost of questionnaire copies and mailing. I would also like to acknowledge and thank Dr. Judith Fischer for permission to use her codependency scale.

Most importantly, I would like to thank my husband Bill and daughter Tara for their continued patience, support, and love.

TABLE OF CONTENTS

SECTION	PAGE
INTRODUCTION.....	3
METHOD.....	13
Participants.....	13
Variables.....	13
Materials.....	13
Procedures.....	15
RESULTS.....	15
DISCUSSION.....	17
REFERENCES.....	21
APPENDICES.....	25
Appendix A. Signed Approval Forms.....	25
Appendix B. SFCDS Survey and Demographic Questionnaire.....	26
Appendix C. Permission to use SFCDS Instrument.....	31

LIST OF TABLES

TABLE	PAGE
1. Descriptive Statistics for SFCDS Data	16

LIST OF FIGURES

FIGURE	PAGE
1. Mean SFCDs score by cancer history and ability to express anger	18

Measuring Codependency in Breast Cancer Survivors

Lynda M. Ciano

San Jose State University

Running Head: MEASURING CODEPENDENCY IN BREAST CANCER

Abstract

No research exists on the relationship between the cancer-prone and the codependent personalities, which appear to be two very similar syndromes. An established codependency assessment tool, the Spann-Fischer Codependency Scale (SFCDS) was administered to a group of 56 breast cancer survivors and 56 women who have not had cancer in an effort to determine whether the survivors score higher on this measure of codependency than the control group. Hypothesis one, which was that there would be a difference between the cancer and no cancer groups on the SFCDS was not supported. However, when the woman's self-report on ability to express anger was introduced as a covariate to breast cancer history, there was a significant difference on the SFCDS scores between groups, suggesting that anger moderates the relationship between codependency and cancer in some way. Hypothesis two, which was that women who have had breast cancer would report more difficulty expressing anger than women who have not had breast cancer, was not supported. By understanding the relationship between codependency and cancer, those women at risk for cancer may become targeted for intervention.

Measuring Codependency in Breast Cancer Survivors

In 1989 496,200 people died of cancer in the United States (U.S. Department of Commerce, 1992, p. 84). This number constitutes 23.1% of the total deaths from all causes. Although medical science has been able to improve the mortality rates for some cancers, such as childhood leukemia or lymphoma, other types defy modern methods. Some forms of cancer seem to have identifiable physical causes, for example, asbestos or tobacco smoke precipitating lung cancer. Most cancers, however, have no known causes, only risk factors, such as high fat diet, early menarche, or delayed child-bearing in breast cancer. The purpose of the current study was to address the lack of research on the identifiable personality and coping style types as established in childhood that may serve to identify those individuals at risk for cancer.

Although cancer is a physical disease, personality factors involved in disease presentation and prognosis (outcome) have long been suspected (Cox & Mackay, 1982). During the second century the physician Galen, in de Tumoribus, reportedly observed that melancholic women developed breast cancer more often than sanguine women (Bahnsen, 1981). Later, in 1701, Gendron wrote that women with serious depression and high anxiety were prone to cancer, while Guy linked "hysteric and nervous complaints," "the dull heavy phlegmatic and melancholic dispositions," and "disasters in life" to the etiology of cancers in women (Cox & Mackay, 1982, p. 383). In the early 1800s, Walshe noted that "women of high colour and sanguinous temperament were more subject to mammary cancer than those of a different constitution [and that] moral emotions produce defective innervation, this perversion of nutrition in turn causes the formation of carcinoma" (Cox & Mackay, 1982, p. 383). At about the same time, James Paget, in Surgical Pathology,

suggested that: "The cases are so frequent in which deep anxiety, deferred hope and disappointment are quickly followed by the growth and increase of cancer that we can hardly doubt that mental depression is a weighty addition to the other influences favoring the development of the cancerous constitution" (Cox & Mackay, 1982, p. 383).

Between 1870 and 1890 there was a surge of psychosomatic statements about cancer in the literature. Most of these statements put great weight on loss, grief, bereavement, or melancholy as a precursor of cancer. For example, Herbert Snow (Cox & Mackay, 1982) wrote about intense emotion causing a loss in vitality and a weakening of the individual's physical ability to fight cancer and was the first person to publish a statistical study demonstrating this relationship. Despite the fact that his methods were quite unsophisticated by today's standards, his conclusions were remarkably in agreement with those of more recent researchers (Cox & Mackay, 1982). For example, Kennedy, Kiecolt-Glaser, and Glaser (1988) investigated how long-term negative effects contribute to the manifestation of cancer and concluded that chronic stress depresses immune function and that the depression of immune function could lead to manifestation of the disease.

Cancer personality generalizations

Ray and Baum (1985) have reviewed the literature concerning the psychodynamic link with cancer extensively. As a result of this review, they have established some personality generalizations of cancer patients. They note that cancer patients are frequently characterized as self-sacrificial (Schmale & Iker, 1971), hypercritical of themselves (LeShan, 1966), unable to express anger and overt hostility (Greer & Morris, 1975; Schonfield, 1975), helpless, anxious, over controlled, hopeless, despairing,

depressed, hypochondriacal, and paranoid (Pauli & Schmid, 1972). Furthermore, cancer patients seem to be anxious, encapsulated, emotionally inhibited, and defensive in their personalities (Bahnsen, 1970; Blumberg et al., 1954; Wirsching, Stierlin, Hoffman, Weber, & Wirsching, 1982).

Furthermore, in an excellent literature review that considered a wide range of empirical works (several of which are reviewed in this paper) on psychological correlates of cancer, Temoshok (1987) interpreted the cancer-prone personality as "Type C" and defined it concisely as, "Abrogating one's needs in favor of those of others, suppressing negative emotion, and being cooperative, unassertive, appeasing, and accepting" (p. 558). However, despite the potential significance of the Type C personality, no studies of its predictive validity have been conducted that attempt to validate it by measuring it objectively as a predictor of cancer.

Type of studies conducted

In the last 40 years, both retrospective and prospective methods have been used to identify personality types or psychological traits that correlate with the incidence of cancer. Most studies have been done retrospectively, that is, after cancerogenesis as well as after the diagnosis of cancer. The remainder were carried out shortly before diagnosis using individuals presenting symptoms suggestive of cancer. The people who were subsequently diagnosed with the disease were then designated as the "experimental" group, while the people with benign conditions served as the control group. While the difference between administering an instrument before the disease exists in the body and before its existence is known to the person may seem to be a fine distinction, Engelman and Craddick (1984) found that the presence of a cancer was known subconsciously by

patients prior to biopsy and, because of this "knowledge," those individuals with malignancies expressed their chance of cure as being more remote. This subconscious awareness could change their measured behaviors and attitudes from pre-cancer states. In the prospective studies, on the other hand, the survey or questionnaire was administered years before the diagnosis of cancer was rendered and, therefore, could not affect behavior in any way.

Review of retrospective empirical studies. During the 1950s and 1960s, interest in the psychosomatic aspects of cancer inspired several studies (Blumberg, West, & Ellis, 1954; Duffy, 1962; Kissen, 1963; LeShan, 1966; Stavrakys, Buck, Lott, & Wanklin, 1968). Reflecting the psychological theory of that time, this literature was set in a very psychodynamic framework and appeared to show: (a) that cancer might be linked to a premorbid behavioral style or personality; and (b) that cancer tended to be preceded by specific emotional distress (Cox & Mackay, 1982).

Continuing and expanding this line of research, Bacon, Renneker, and Cutler (1971) used psychodynamic methods to develop personality profiles for 40 women with breast cancer. They used the following characteristics to describe their participants: (a) masochistic character structure, (b) inhibited sexually, (c) inhibited feelings of motherhood, (d) an inability to deal appropriately with anger, aggressiveness, or hostility, and (e) an unresolved conflict with her mother dating back to childhood. There was also an interesting observation of increased guilt feelings in half of the patients during the year preceding discovery of the breast lump. Jansen and Muenz (1984) found women with breast cancer were more depressed, less aggressive, and less demonstrative than controls. Watson, Greer, Rowden, Gorman, Robertson, Bliss, and Tunmore (1991) tested women

who did not have breast cancer and 359 women in the early stage of the disease. They found a high degree of emotional control, fatalism, and helplessness in the breast cancer group as opposed to the control group.

A recent study by Jensen (1987) linked a repressive personality to the onset and course of breast cancer. Repression, as a personality style defined by Jensen, is when a person does not acknowledge negative emotions, is in denial to a great extent, does not have intense emotional experiences, and tries to hide any internal turmoil from themselves and others. Jensen proposed that it is possible that repressors fail to acknowledge or detect bodily changes that could indicate the presence of breast cancer. Considering all factors suspected to influence the disease, he found that medical variables alone accounted for 23% of the outcome variance whereas psychological variables alone accounted for 44% of the outcome variance. Jensen concluded that, "...individuals with a character style involving reduced attention to distress are at an elevated risk for deterioration or death from cancer" (Jensen, 1987, p.340).

Of course, there is a problem with retrospective studies. Ray and Baum (1985) argue that it is quite possible that in instances where a "diagnosis has already been made...that patient's emotionality or defensiveness, or their general way of viewing themselves and the world, arises from an awareness of cancer and the fact of its treatment. This is a confounding factor affecting all retrospective studies...feelings of despair and hopelessness, defenses such as denial, and the suppression of hostility, are commonly cited as an outcome of the illness, and the observation of these characteristics in cancer patients by no means implies that these traits pre-existed the illness" (p. 34).

Review of prospective empirical studies. Prospective studies do not suffer from

the same confounds as retrospective studies. However, due to the time interval required to effectively conduct prospective studies, very few have been performed. The series of studies conducted by Grossarth-Maticek, Eysenck, and colleagues (Eysenck, 1985; Grossarth-Maticek & Eysenck, 1990; Grossarth-Maticek, Kanazir, Schmidt, & Vetter, 1982) represents one such prospective endeavor, but these studies have been criticized severely for their methodological (problematic sampling techniques, lack of methodological rigor) and interpretational problems (erroneous conclusions) (Levy, 1991). Since the body of evidence provided by Grossarth-Maticek, Eysenck, and colleagues is such a large proportion of the total prospective literature, however, I will review it despite the existing reservations. In addition, the Precursors Study (Thomas & Duszynski, 1974) conducted at Johns Hopkins Medical School between 1948 and 1964 will be reviewed as a prospective study.

Grossarth-Maticek et al. (1982) reviewed prospective data from a Yugoslavian study of 1,353 people over the age of 50 conducted in 1966. They found that chronic helplessness and anti-emotional behavior correlated with a later diagnosis of cancer. Also, Eysenck (1985) found that anti-emotional behavior and low neuroticism were highly correlated with a later diagnosis of cancer based on a West German study randomly administered to 1,026 people in 1972. In addition to correlating personality factors with the incidence of cancer, Eysenck and his colleagues attempted to not only predict high-risk-for-cancer individuals but also therapeutically intervene with various forms of therapy in an effort to decrease the incidence of the disease. They found that creative novation therapy (a cognitive behavior therapy that targets the relief of depression and hopelessness and encourages the expression of emotions) was significantly more effective at decreasing

manifestation of the disease than either psychotherapy or behavioral therapy (Eysenck, 1987).

The Personality-Stress Questionnaire that Grossarth-Maticek and Eysenck (1990) used to predict particular disease-prone individuals has six sub-scales that are used to classify participants into one of six disease "types." The first type is cancer-prone and, since the last five types are not relevant to the topic of this study, they will not be considered further. The survey was administered to 748 people and the first 36 who scored high in each type and very low in all other types were designated to that particular category and followed for 13 years. Of the 36 cancer-prone individuals, 11 were diagnosed with the disease during the 13 years of the study. Of the 180 people classified in a different type (i.e., low in cancer-prone tendencies), 11 were diagnosed with cancer. Of the 36 individuals classified as cancer-prone, 20 were diagnosed with other diseases (i.e., CHD, addiction, etc.) for which they should have been at very low risk. The remaining 5 cancer-prone individuals were not diagnosed with any disease during the 13 year duration of the study (Grossarth-Maticek & Eysenck, 1989).

In another study, Grossarth-Maticek, Eysenck, and Vetter (1988) manipulated combinations of chemotherapy and psychotherapy between groups. The participants were women with terminal breast cancer, all of whom were offered chemotherapy. They found that women who were assigned to the psychotherapy groups lived significantly longer than patients not given psychotherapy, regardless of whether they received chemotherapy or not.

Another instrument that has been used to predict the cancer-prone personality is the Family Attitude Questionnaire (FAQ). This survey was part of the Precursors Study

(Thomas & Duszynski, 1974) conducted at Johns Hopkins Medical School between 1948 and 1964. A factor analysis was performed on the FAQ in an attempt to discern those familial factors that correlated with subsequent disease states of the 1,185 white, male, medical student participants at Johns Hopkins who graduated between 1948 and 1964. By 1974, 20 of the medical students who had completed the FAQ had been diagnosed with cancer. After matching these individuals with comparable age controls, Thomas and Duszynski found that the cancer group, compared with the non-cancer participants, showed significantly lower scores on the Closeness-to-Parents sub-scale of the FAQ. Sub-scales measuring Father's Age at Participant's Birth, Mother's Age at Participant's Birth, Emotional Demonstrativity, and Matriarchal Dominance did not show significant results.

Grassi and Molinari (1987) also used the FAQ to evaluate women who presented symptoms suggestive of either breast or uterine cancer. Like Thomas and Duszynski (1974), the women later found to have breast cancer showed decreased scores on the Closeness-to-Parents sub-scale but were also lower on the Demonstrativity, the Good Paternal Relationship, and the Good Maternal Relationship sub-scales when compared to the control group of women later found to have benign conditions. Why Grassi and Molinari's (1987) conclusions were not the same as Thomas and Duszynski's (1974) on the Demonstrativity, the Good Paternal Relationship, and the Good Maternal Relationship sub-scales on the same measure can perhaps be explained by Hagnell (1962), who found that women, who were the participants in the Grassi and Molinari study, show stronger correlations between psychological factors and cancer than men, who were the participants in the Thomas and Duszynski study.

Codependency and Cancer-prone Personality Concept

A seemingly unrelated construct to cancer-prone personality that may help identify those individuals at risk for cancerogenesis and may provide an efficient and indirect measure of cancer-prone tendencies is "codependency." Codependency is a psychosocial condition and the definition of this construct is similar to the profile that was drawn from the previously outlined empirical studies of the cancer-prone personality (i.e., self-sacrificial, hypercritical of themselves, unable to express anger overtly, etcetera). Fischer, Spann and Crawford (1991) have defined the codependent pattern as having "extreme focus outside of self, lack of open expression of feelings, and, attempts to derive a sense of purpose through relationships" (p. 88). Based on this definition, Fischer et al. (1991) operationalized this construct in a measure of codependency, the Spann-Fischer Codependency Scale (SFCDS). If cancer-prone personality and codependency are related, cancer patients (who, because they got cancer theoretically are, or were, cancer-prone) should score higher on the SFCDS than people who have not had cancer. Further, perhaps the field treatment strategies of the relatively nonanalytic (codependency has not yet been the focus of many analytical studies) dimension of codependency might be applied with some success to cancer-prone personalities to either decrease the chance of recurrence (improve the prognosis) or, before cancerogenesis, to prevent manifestation of the disease.

The origins of cancer-prone tendencies are not known; however, codependency is seen as a direct result of childhood experiences, parental influences, and coping strategies adopted by the individual (Wegscheider-Cruse, 1985). Although the link between codependency and cancer is new, the implication of childhood affect (i.e., emotion and

coping) in carcinogenesis has been studied extensively (Bahnson, 1981; Bahnson & Bahnson, 1969; Grassi & Molinari, 1987; Thomas & Duszynski, 1974). Bahnson (1981) offered an explanation why only some people get cancer by suggesting that cancer occurs only when there is an interaction between certain personality traits and certain childhood events. He proposed that unresolved conflicts from childhood, including fixation on one of the parents, could lead to denial and problems with interpersonal relationships in adulthood. He further suggested that suppression of the unresolved conflicts requires "compensatory management" (p.212) of affect, which breaks down shortly before the manifestation of cancer.

The first purpose of this study was to examine codependent characteristics in cancer survivors. No causality, either from cancer to codependency or from codependency to cancer is implied. The research question considered was: Is there a difference on a measure of codependency between people who have had cancer and people who have not had cancer? The second purpose of this study was to consider the difference in ability to express anger between women who have had breast cancer and women who have not had cancer.

Specifically, my first hypothesis is that cancer survivors will score higher on the SFCDS than people who have not had cancer, based on the parallels that exist between the cancer-prone and the codependent personalities. Although in this study cancer history is used to predict the SFCDS score, I hope that, in the future, the SFCDS score, along with other predictors, will be used to predict vulnerability to cancer. My second hypothesis is that women who have had breast cancer will report more difficulty in expressing anger than women who have not had breast cancer, based on the findings that cancer-prone

personalities are unable to express anger (Greer & Morris, 1975; Schonfield, 1975).

Method

Participants

Participants were 112 women between the ages of 29 and 81 ($M = 53.92$, $SD = 11.26$). Fifty-six of the women who have had breast cancer comprised the "experimental" group. The other 56 constituted the comparison group and consisted of women who had not had any type of cancer. Breast cancer survivors were contacted based on names and addresses of qualified participants from the American Cancer Society and through a local oncology office. Control participants were recruited through local beauty parlors, doctor's offices, a Visiting Nurse Association office, and real estate offices. Breast cancer survivors and controls were subsequently matched for age and ethnicity. Socioeconomic status was not measured.

Variables

The grouping variable was cancer history, and was dichotomously coded as yes/no. One criterion variable was the score on the SFCDS, and the second was the participant's self-report on ability to express anger (very well, good, fair, poor) with a further clarification requested on the change in her ability to express anger (better than I used to, worse than I used to).

Materials

Codependency. The Spann-Fisher Codependency Scale (see Appendix C for complete survey) is a 16-item survey that was constructed based on Fischer and Spann's definition of codependency as being other-oriented, rather than self-oriented, and an inability to express negative emotion (Fischer & Spann, 1991). The resulting 15-item

scale had a test-retest correlation of .87 and an internal consistency coefficient of .86. A sixteenth item was added to the scale, for an unspecified reason, to comprise the scale as it exists today. Each item is rated on a six point Likert-type scale (1 = strongly disagree, 2 = moderately disagree, 3 = slightly disagree, 4 = slightly agree, 5 = moderately agree, 6 = strongly agree). All responses were totaled such that higher scores indicated greater codependent tendencies. In this study, each question was followed by further clarification of responses from cancer survivors asking for an estimate of change in magnitude of the characteristic in a "better than/worse than I used to be" format. These data will be used for exploratory purposes in an effort to understand why these women are cancer survivors when so many others die.

Cancer History. In addition, a demographic questionnaire (see Appendix C for complete survey) was used to record cancer history status, as well as age and ethnicity information for matching purposes. Cancer history was coded yes/no for history of cancer in general and breast cancer in specific. Finally, there were several questions regarding the participant's family-of-origin, again following a yes/no response format, in order to help understand the test scores. Further clarification was requested on yes responses, such as the relationship of the person involved (i.e., father, mother, sibling, etc.), and the type of addiction involved (i.e., alcohol, drugs, gambling, overeating, or other). Questions concerning ability to express anger, with a "very well," "good," "fair," or "poor" response format and further clarification requested indicating any change in this ability in a "better than I used to," "worse than I used to" format, and availability of support from family-of-origin members were also included.

Procedures

A copy of the SFCDS, along with the demographic questionnaire and informed consent forms were mailed to the list of cancer survivors obtained from the various organizations specified above. A total of 114 surveys were mailed and 59 were returned (51.8%). Concurrently, comparison participants were recruited through a box with the questionnaires in two beauty parlors, a physician's office, and a local visiting nurse's office. Three hundred surveys were placed and 91 were returned (30.3%). Follow-up telephone calls and/or postcards were used in order to assure maximum return rates. Three surveys from cancer survivors were excluded from analyses, two due to incomplete data, and the third due to multiple answers given for each question. The remaining 56 cancer survivor surveys were then matched to surveys of 56 women who had not had cancer on age and ethnicity. However, participants could not be easily matched on age. Two separate sets of data were analyzed due to the inability to match participants adequately for age. The large sample consists of 112 sets of data matched for ethnicity and the age $M=57.84$ years for cancer survivors and $M=50.00$ years for controls. The small sample consists of data from 74 participants who were perfectly matched for ethnicity and age, $M=53.19$ years for both groups. Since qualitative (i.e., significance levels of inferential statistics) results for both groups were identical, results are presented for the large group only.

Results

Descriptive statistics for the breast cancer and control group's SFCDS scores are presented in Table 1.

The first hypothesis, that breast cancer survivors would score higher than women who have not had cancer on the SFCDS was not supported, $t(112) = .29$, $p = .772$.

Table 1

Descriptive Statistics for SFCDS Scores by Breast Cancer History

Statistic	Had Breast Cancer	No Cancer
Sample size (N)	56	56
Mean of SFCDS	45.34	44.64
Standard Deviation	13.25	12.09
Range (minimum/maximum)	17-78	24-88

However, when the self-reported ability to express anger was introduced as a covariate to breast cancer history, there was a significant difference between the groups on the SFCDS, $F(1,109) = 11.70, p = .001$. The second hypothesis, that women who have had breast cancer would report more difficulty expressing anger (grouping categories for expressing anger were "well," "good," "fair," and "poor") than women who have not had breast cancer was not supported, $F(3,109) = 2.518, p = .062$.

Discussion

The results of the present study do not support the hypothesis that breast cancer survivors score higher than a control group on a measure of codependency. However, when the woman's ability to express anger is held constant (i.e., entered as a covariate), a significant difference between the groups is observed. This indicates that women who have had breast cancer and who have trouble expressing anger test higher on the codependency measure than women who have had breast cancer and express anger well or those women who have not had breast cancer (see Figure 1). The fact that the women who have had breast cancer and yet reported that they express their anger very well scored the lowest on the SFCDS indicates that the SFCDS is accurate at revealing the trend and may very well be an indication of a more substantial link between the concepts of codependency and cancer-proneness. The substance of the trend is a question that may be addressed in future research.

Findings from previous research have suggested there should be a main effect on the ability to express anger between women who have had breast cancer and women who have not had breast cancer. However, ability to express anger was measured in this study by one self-report question, and this item has not yet been validated. Future researchers

Figure Caption. Mean SFCDS scores by cancer history and ability to express anger

who wish to look at how the SFCDs predicts one's ability to express anger may consider using a more comprehensive measure of ability to express anger that has been evaluated for reliability and validity.

However, it cannot be overlooked that the mean survival time of these breast cancer survivors is 7.59 years, which, due to the gravity and high morbidity of the disease in general is, in itself, an impressive feat. This impressive survival time suggests that any codependent pattern that may have existed could have been changed due both to time and to the psychological adjustments that occur with diagnosis and treatment. The overall percentage of women diagnosed with breast cancer who survive five years is somewhat less than 75% (Holleb, 1986). The women who participated in this study therefore, by virtue of their survival, comprise a very extraordinary group. Due to this uniqueness, this sample is not generalizable to women at risk for breast cancer because they have not yet experienced and survived the trauma of diagnosis of cancer, treatment of that cancer, and the ensuing life and attitude changes that result from this trauma. Future researchers who pursue this line of inquiry may consider using a breast cancer population similar to those participants used by Grassi and Molinari (1987), that is, women seeking medical care for undiagnosed breast masses. Although the women who are ultimately diagnosed with breast cancer are prone to vast differences in responses, this sample would more closely represent the target population of interest.

As previously stated, the breast cancer survivor group had a mean survival time of 7.59 years. This fact imposed serious limitations on the amount of valuable information that could come of this study as these women, by virtue of their disease-free survival time, can no longer be considered to be cancer-prone, as most reoccurrences of cancer occur

within five years of the original diagnosis. As indicated above, the women who were diagnosed with breast cancer over the past 7.59 years who have died of the disease are not represented in these data. In addition, the use of a 1-item self-report question on ability to express anger apparently missed a wealth of information that may prove to be critical in the evaluation of how codependency and cancer-proneness may be related. A more comprehensive, objectively evaluated instrument should be considered for this measure in any future work that considers the same questions as this thesis.

However, due to the promising results of this study, the connection between codependency and cancer, if given further support, could offer hope for longer life to the 12.5% of American women who are projected to be diagnosed with breast cancer within their lifetime. This disease is of epidemic proportions and, although medical treatment has made small strides within the past 30 years in survival times, the burden for significantly improving this prognosis may very well rest on psychological changes within women themselves. Many people believe that, if certain personality variables are correlated with cancer, they are somehow at fault or somehow to blame. It must be emphasized that the purpose of this study is, in no way to place any blame on the woman who is diagnosed with breast cancer. Instead, child-rearing practices and societal influences may have placed an inordinate amount of stress on these women, and the stress, currently, has no avenue for catharsis. If codependency, which is certainly caused by influences outside of the "designated patient," is implicated in the manifestation of breast cancer, this will, instead, give women an effective means of countering this destructive societal influence and learning how to take better care of themselves in this fast-paced, ever-changing world that we live in.

References

- Bacon, C.L., Renneker, R., & Cutler, M. (1971). A psychosomatic survey of cancer of the breast. Psychosomatic Medicine, 14, 453-460.
- Bahnsen, C.B. (1970). Basic epistemological considerations regarding psychosomatic processes and their application to current psychophysiological cancer research. International Journal of Psychobiology, 1, 57-69.
- Bahnsen, C.B. (1981). Stress and cancer: The state of the art. Part 2. Psychosomatics, 22, 207-220.
- Bahnsen, M.B. & Bahnsen, C.B. (1969). Ego defenses in cancer patients. Annals of the New York Academy of Sciences, 164, 546-559.
- Blumberg, E.M., West, P.M., & Ellis, F.W. (1954). A possible relationship between psychological factors and human cancer. Psychosomatic Medicine, 16, 277-286.
- Cox, T. & Mackay, C. (1982). Psychosocial factors and psychophysiological mechanisms in the aetiology and development of cancers. Social Science and Medicine, 16, 381-396.
- Duffy, E. (1962). Activation and Behavior. New York: Wiley.
- Engelman, S.R., & Craddick, R. (1984). The symbolic relationship of breast cancer patients to their cancer, cure, physician, and themselves. Psychotherapy and Psychosomatics, 41, 68-76.
- Eysenck, H.J. (1985). Personality, cancer, and cardiovascular disease: A causal analysis. Personality and Individual Differences, 6, 535-556.
- Eysenck, H. J. (1987). Anxiety, learned helplessness, and cancer: A causal theory. Journal of Anxiety Disorders, 1, 87-104.

- Fischer, J. L., Spann, L., & Crawford, D. (1991). Measuring Codependency. Alcoholism Quarterly, 8, 87-99.
- Grassi, L. & Molinari, S. (1987). Family affective climate during the childhood of adult cancer patients. Journal of Psychosocial Oncology, 4, 53-62.
- Greer, S., & Morris, T. (1978). The study of psychological factors in breast cancer: Problems of method. Social Science Medicine, 12, 129-134.
- Greer, S., & Morris, T. (1975). Psychological attributes of women who develop breast cancer: A controlled study. Journal of Psychosomatic Research, 19, 147-153.
- Grossarth-Maticek, R., & Eysenck, H. (1990). Personality, stress and disease: Description and validation of a new inventory. Psychological Reports, 66, 355-373.
- Grossarth-Maticek, R., Eysenck, H., & Vetter, H. (1988). Personality type, smoking habit and their interaction as predictors of cancer and coronary heart disease. Personality and Individual Differences, 9, 479-495.
- Grossarth-Maticek, R., Kanazir, D., Schmidt, P., & Vetter, H. (1982). Psychosomatic factors in the process of carcinogenesis: Theoretical models and empirical results. Psychotherapy and Psychosomatics, 38, 284-302.
- Hagnell, O. (1962). The premorbid personality of persons who develop cancer in a total population investigated in 1947 and 1957. Annals of the New York Academy of Sciences, 157, 846-855.
- Holleb, A.I. (1986). The American Cancer Society Cancer Book. New York: Doubleday.
- Jansen, M. A., & Muenz, L. R. (1984). A retrospective study of personality variables

associated with fibrocystic disease and breast cancer. Journal of Psychosomatic Research, 28, 35-42.

Jensen, M.R. (1987). Psychobiological factors predicting the course of breast cancer. Journal of Personality, 55, 317-342.

Kennedy, S., Kiecolt-Glaser, J., & Glaser, R. (1988). Immunological consequences of acute and chronic stressors: Mediating the role of interpersonal relationships. British Journal of Medical Psychology, 61, 77-85.

Kissen, D.M. (1963). The significance of syndrome shift and late syndrome association in psychosomatic medicine. Journal of Nervous and Mental Disorders, 136, 34-43.

LeShan, L. (1966). An emotional life-history pattern associated with neoplastic disease. Annals of the New York Academy of Sciences, 125, 780-793.

Levy, S. (1991). Personality as a host risk factor: Enthusiasm, evidence, and their interaction. Psychological Inquiry, 2, 254-257.

Pauli, H.K., & Schmid, V. (1972). Psychosomatic aspects in the clinical manifestation of breast cancers. Journal of Psychotherapy and Medicine, 22, 76-80.

Ray, C., & Baum, M. (1985). Psychological aspects of early breast cancer. New York: Springer.

Schmale, A., & Iker, H. (1971). Hopelessness as a predictor of cervical cancer. Social Science and Medicine, 5, 95-100.

Schonfield, J. (1975). Psychological and life experiences differences between Israeli women with benign and cancerous breast lesions. Journal of Psychosomatic Research, 19, 229-236.

- Stavraky, K.M., Buck, C.W., Lott, S.S., & Wanklin, J.M. (1968). Psychological factors in the outcome of human cancer. Journal of Psychosomatic Research, 12, 251-259.
- Temoshok, L. (1987). Personality, coping style, emotion and cancer: Towards an integrative model. Cancer Surveys, 6, 545-567.
- Thomas, C.B. & Duszynski, K.R. (1974). Closeness to parents and the family constellation in a prospective study of five disease states: Suicide, mental illness, malignant tumor, hypertension and coronary heart disease. The Johns Hopkins Medical Journal, 134, 251-270.
- United States Department of Commerce. (1992). Statistical abstract of the United States, 112th ed. Washington, D. C.: United States Department of Commerce.
- Watson, M., Greer, S., Rowden, L., Gorman, C., Robertson, B., Bliss, J., & Tunmore, R. (1991). Relationships between emotional control, adjustment to cancer, and depression and anxiety in breast cancer patients. Psychological Medicine, 21, 51-57.
- Wegscheider-Cruse, S. (1985). Choice-making. Pompano Beach, FL.: Health Communications, Inc.

Appendix A

Signed Approval Form

A campus of The California State University

Office of the Academic Vice President • Associate Academic Vice President • Graduate Studies and Research
One Washington Square • San José, California 95192-0025 • 408/924-2480

To: Lynda Ciano
1165 Carr Ave.
Aromas, CA 95004

From: Serena W. Stanford *Serena W. Stanford*
AAVP, Graduate Studies and Research

Date: October 20, 1993

The Human Subjects-Institutional Review Board has approved your request to use human subjects in the study entitled:

"Type C Personality as a Subset of Codependency"

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research project, and with regard to any and all data that may be collected from the subjects. The Board's approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Dr. Serena Stanford immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised that each subject needs to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at anytime. Further, a subject's participation, refusal to participate or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted. If you have questions, please contact me at 408-924-2480.

Appendix B

SFCDS Survey and Demographic Questionnaire

INSTRUCTIONS: PLEASE CIRCLE THE APPROPRIATE RESPONSE.
 CANCER SURVIVORS ONLY: PLEASE ANSWER BOTH SECTIONS OF EACH QUESTION.

1. It is hard for me to make decisions.

1. strongly disagree	2. moderately disagree	3. slightly disagree	4. slightly agree	5. moderately agree	6. strongly agree
-------------------------	---------------------------	-------------------------	----------------------	------------------------	----------------------

Cancer survivors only: This has changed for me since my diagnosis. yes no

If yes: I am:	better than I used to be	worse than I used to be
---------------	-----------------------------	----------------------------

2. It is hard for me to say "no."

1. strongly disagree	2. moderately disagree	3. slightly disagree	4. slightly agree	5. moderately agree	6. strongly agree
-------------------------	---------------------------	-------------------------	----------------------	------------------------	----------------------

Cancer survivors only: This has changed for me since my diagnosis. yes no

If yes: I am:	better than I used to be	worse than I used to be
---------------	-----------------------------	----------------------------

3. It is hard for me to accept compliments graciously.

1. strongly disagree	2. moderately disagree	3. slightly disagree	4. slightly agree	5. moderately agree	6. strongly agree
-------------------------	---------------------------	-------------------------	----------------------	------------------------	----------------------

Cancer survivors only: This has changed for me since my diagnosis. yes no

If yes: I am:	better than I used to be	worse than I used to be
---------------	-----------------------------	----------------------------

4. Sometimes I almost feel bored or empty if I don't have problems to focus on.

1. strongly disagree	2. moderately disagree	3. slightly disagree	4. slightly agree	5. moderately agree	6. strongly agree
-------------------------	---------------------------	-------------------------	----------------------	------------------------	----------------------

Cancer survivors only: This has changed for me since my diagnosis. yes no

If yes: I am:	better than I used to be	worse than I used to be
---------------	-----------------------------	----------------------------

5. I usually *do not* do things for other people that they are capable of doing for themselves.

1. strongly disagree	2. moderately disagree	3. slightly disagree	4. slightly agree	5. moderately agree	6. strongly agree
-------------------------	---------------------------	-------------------------	----------------------	------------------------	----------------------

Cancer survivors only: This has changed for me since my diagnosis. yes no

If yes: I am:	better than I used to be	worse than I used to be
---------------	-----------------------------	----------------------------

6. When I do something nice for myself I usually feel guilty.

1. strongly disagree	2. moderately disagree	3. slightly disagree	4. slightly agree	5. moderately agree	6. strongly agree
-------------------------	---------------------------	-------------------------	----------------------	------------------------	----------------------

Cancer survivors only: This has changed for me since my diagnosis. yes no

If yes: I am:	better than I used to be	worse than I used to be
---------------	-----------------------------	----------------------------

7. I *do not* worry very much.

1. strongly disagree	2. moderately disagree	3. slightly disagree	4. slightly agree	5. moderately agree	6. strongly agree
-------------------------	---------------------------	-------------------------	----------------------	------------------------	----------------------

Cancer survivors only: This has changed for me since my diagnosis. yes no

If yes: I am:	better than I used to be	worse than I used to be
---------------	-----------------------------	----------------------------

8. I tell myself that things will get better when the people in my life change what they are doing.

1. strongly disagree	2. moderately disagree	3. slightly disagree	4. slightly agree	5. moderately agree	6. strongly agree
-------------------------	---------------------------	-------------------------	----------------------	------------------------	----------------------

Cancer survivors only: This has changed for me since my diagnosis. yes no

If yes: I am:	better than I used to be	worse than I used to be
---------------	-----------------------------	----------------------------

9. I seem to have relationships where I am always there for them but they are rarely there for me.

1. strongly disagree	2. moderately disagree	3. slightly disagree	4. slightly agree	5. moderately agree	6. strongly agree
-------------------------	---------------------------	-------------------------	----------------------	------------------------	----------------------

Cancer survivors only: This has changed for me since my diagnosis. yes no

If yes: I am:	better than I used to be	worse than I used to be
---------------	-----------------------------	----------------------------

10. Sometimes I get focused on one person to the extent of neglecting other relationships and responsibilities.

1. strongly disagree 2. moderately disagree 3. slightly disagree 4. slightly agree 5. moderately agree 6. strongly agree

Cancer survivors only: This has changed for me since my diagnosis. yes no

If yes: I am: better than I used to be worse than I used to be

11. I seem to get into relationships that are painful for me.

1. strongly disagree 2. moderately disagree 3. slightly disagree 4. slightly agree 5. moderately agree 6. strongly agree

Cancer survivors only: This has changed for me since my diagnosis. yes no

If yes: I am: better than I used to be worse than I used to be

12. I don't usually let others see the "real" me.

1. strongly disagree 2. moderately disagree 3. slightly disagree 4. slightly agree 5. moderately agree 6. strongly agree

Cancer survivors only: This has changed for me since my diagnosis. yes no

If yes: I am: better than I used to be worse than I used to be

13. When someone upsets me I will hold it in for a long time, but once in a while I explode.

1. strongly disagree 2. moderately disagree 3. slightly disagree 4. slightly agree 5. moderately agree 6. strongly agree

Cancer survivors only: This has changed for me since my diagnosis. yes no

If yes: I am: better than I used to be worse than I used to be

14. I will usually go to any lengths to avoid a conflict.

1. strongly disagree 2. moderately disagree 3. slightly disagree 4. slightly agree 5. moderately agree 6. strongly agree

Cancer survivors only: This has changed for me since my diagnosis. yes no

If yes: I am: better than I used to be worse than I used to be

15. I often have a sense of dread or impending doom.

1. strongly disagree 2. moderately disagree 3. slightly disagree 4. slightly agree 5. moderately agree 6. strongly agree

Cancer survivors only: This has changed for me since my diagnosis. yes no

If yes: I am: better than I used to be worse than I used to be

16. I often put the needs of others ahead of my own.

1. strongly disagree 2. moderately disagree 3. slightly disagree 4. slightly agree 5. moderately agree 6. strongly agree

Cancer survivors only: This has changed for me since my diagnosis. yes no

If yes: I am: better than I used to be worse than I used to be

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. NOW PLEASE ANSWER THE FOLLOWING QUESTIONS SO THAT THE INFORMATION CAN BE CORRECTLY TABULATED. CIRCLE RESPONSES OR FILL IN THE BLANKS AS NEEDED.

Age_____

Ethnicity White Mexican-American African-American Asian Other_____

Have you ever had cancer? YES NO

Have you ever had breast cancer? YES NO

If yes, age at diagnosis_____ Premenopausal Postmenopausal

Have you had counseling since your diagnosis? YES NO

If yes, what type? Individual Group Other_____

Please circle the "roles" you held at the time of diagnosis:

wife mother employee single mom other_____

Do you have a family history of breast cancer? YES NO

If yes, in whom? mother sister other

Did you grow up with parental addiction (i.e., alcohol or drug abuse, overeating, gambling, etc.)

YES NO

If yes, please specify type_____

Were other extreme conditions, (i.e. parental obsessive-compulsive behavior, child abuse, etc.)
part of your childhood? YES NO

Does an addiction play an important part in your adult life? YES NO

If yes, please specify type_____ and in whom_____

How effectively do you express anger?

very well good fair poor

Also rate: Better than I used to the same worse than I used to

Do you feel that your life has been well-balanced on how much you have nurtured others
versus how much others have nurtured you? YES NO

Do you still live in the general area (within about 100 miles) of where you grew up?

YES NO

Are there members of your family-of-origin close enough (within about 100 miles) to lend you
moral support?

YES NO NOT APPLICABLE TO ME

Do you believe that you have:

Strong Social Support	Medium Social Support	Weak Social Support	No Social Support
--------------------------	--------------------------	------------------------	----------------------

THANK YOU FOR FILLING OUT THIS QUESTIONNAIRE!

Appendix C

Permission to use SFCDS Instrument

OCT- 7-93 THU 14:35

COMMUNICATION SER. -TTU

FAX NO. 806/421343

F.01

TEXAS TECH UNIVERSITY

Department of Human Development
& Family StudiesBox 41162
Lubbock, TX 79409-1162
(806) 742-3000

Post-It™ brand fax transmittal memo 7671		# of pages •
To	Lynda Crane	From
Co.		Co.
Dep.		Phone #
Fax #	408-726-2645	Fax #

Dr. Fischer

TTU

(806) 742-3000

(806) 742-1343

10/7/93

TO WHOM IT MAY CONCERN:

If you need written permission to use the Spann-Fischer Codependency Scale, please consider this letter as conferring such consent. Permission to use the scale in no way invalidates the copyright.

We are pleased to learn of your interest in our research on codependency. Because this is a topic of ongoing study for us, would you be so kind as to send to us a copy of your paper or thesis/dissertation abstract when you are finished with your research?

Best of luck with your research.

Sincerely,

Judith L. Fischer, Ph. D.
Professor