CHAPTER THREE

PSYCHOSOCIAL ADAPTATION EFFORTS OF CANCER PATIENTS
FOR SURVIVAL
3.1 Cope With Stress For Psychosocial Adaptation:

Individuals under critical situations of life, uncongenial psychosocial climate, and in facing any unusualities generate physiological systemic stress — when the balanced condition of internal environment (within body) is disturbed and through natural systemic effort is regained. By nature, physiological systems have innate flexibility to adapt with number of unavoidable stress of daily life — by restoring homeostatic condition of the body. Each individual is endowed with physiological limits to adapt with the stress of usual life and ability to stretch the limit up to certain extent under emergency. The problem arises when circumstances strike hardly on the physiological limits and last longer duration or by crossing the threshold of imagination; and make the mind of the said individual involve to keep pace with that unusual effect of stress or distress. The said 'Keeping pace efforts and psychodynamics' is described as 'Coping'. In the present context, coping may be considered as 'a special effort for Psychosocial adaptation' of the victim with carcinogenic stress of longer duration and his/her short-sight with its unimaginable consequences.

Being confronted with traumatic life events and their sequel of longer duration, the victims generally take resort to a wide range of coping strategies to alleviate the resultant distress. The conceptual underpinnings of much of the recent empirical developments in the field of coping with stress and trauma can be traced to the work of Lazarus and his coworkers (e.g., Lazarus, 1993; Lazarus and Folkman, 1984). These writers viewed the process of coping as comprised of two distinct phases: (a) primary appraisal, which refers to a set of cognitions concerning the significance or impact of the stressful event for
the individual, and (b) secondary appraisal, which refers to a set of cognitions regarding the availability of resources or options (e.g., coping skill) for dealing with the stressful situation. Coping dynamics is controlled by the individual's native Psychic Constitution (its peculiarities) and his/her individuated (phenomenal) experiences. Here, breast cancer may be treated as an independent variable manipulated by the individual's external environment.

3.1.1 Coping With Carcinogenic Distress:

In relation to breast cancer patients' long and longer time survival, most frequently researched coping styles are maneuvered — (a) internal vs. external locus of behaviour control; (b) optimism vs. pessimism or a feeling of learned helplessness; (c) repression of emotion or blunting vs. sensitization or monitoring; and (d) approach vs. avoidance.

(a) Internal vs. External Locus Of Behaviour Control: Results of many studies generally suggest that both internal and external controls are associated with better psychosocial adaptation and curbing depression. The first or the victim's own self controlling the distress (internal or personal locus of control). The second one is that powerful figures in the external world, such as medical personnel could control the disease. Blaming others for the onset or recurrence of the disease or lack of medical control is more commonly linked to poorer adaptation (Taylor et al., 1984). Some divergent findings, however, were obtained by Jenkins and Pergament (1988), who reported that perceptions of behaviour control were differentially associated with measures of self-esteem and nurses ratings of behavioural upset. Also, higher levels of inability to control emotional reactions were related to lower self-esteem and poorer adjustment to the illness.
(b) Optimism vs. Pessimism: Optimism vs. Pessimism was also found to be negatively related to psychosocial distress (Stanton and Snider, 1993). Optimistic outlook was found associated with an increased sense of well-being, increased psychosocial adjustment, decreased psychosocial stress, and renewed vigor among women with breast cancer (Miller, Manne, Taylor, Keates and Dougherty, 1996; Stanton and Snider, 1993).

(c) Repression/Blunting vs. Sensitization/Monitoring: Here, the term repression refers to suppressing the distress by intense self-effort. It is an alternative form of blunting, minimizing and rejecting — a defensive step in which the individual employs strategies to void or negate by self-effort, the awareness of affects and impulses. Sensitization, or as it is occasionally termed, monitoring, exaggerating and attending, refers to efforts directed at acknowledging, focusing on and adopting vigilant attentional style when faced with threatening affects and impulses (Krohne, 1996; Weinberger and Schwartz, 1990). Cancer specific minimization and denial, as opposed to exaggeration of the cancer's negative aspects, emerged as the variable most strongly associated with decreased levels of distress among women who underwent mastectomy (Meyerowitz, 1983). Ward, Leventhal and Love (1988) reported that repressor patient groups had developed tolerable side-effects of chemotherapy. In explaining the rationale behind the above tolerable side-effects of repressor group, Lerman et al (1990 and 1996) remarked that the repressor group generally develop a 'blunting' — an immunity to think of future consequences and loss of interest to acquire further information. Obviously, they did not feel the necessity to formulate any coping strategy and expressed less anticipatory anxiety, less depression and less nausea. According to them, remaining free of
'blunting'. Few of them could adopt opposite path to monitor their future by collecting information from others. Those few cases used to develop more anxiety, more nausea, and suffer from more psychosocial distress. It suggested that who would follow which path, as repressor, depend on their native psychic constitution — regardless of counselling approach undertaken.

(d) Approach vs. Avoidance: In several studies, researchers reported that persons with cancer who adopted an avoidant, rather than confrontive, coping style had higher levels of depression (Keyes et al., 1987; Mumby, Siston and Williams, 1996), sickness-related or physical symptoms (Keyes et al., 1987; Shapiro et al., 1997) and generalized psychosocial distress (Miller et al., 1996). Similarly, Chen et al. (1996) concluded that engagement (i.e., approach) strategies were significantly correlated with a decreased level of psychiatric distress among women with breast cancer.

Within the broader classification system that categorizes coping strategies as operating principally along an engagement (e.g., approach, confrontive) versus disengagement (e.g., avoidance, escape) continuum (Carver et al., 1989; Krohne, 1996; Tobin et al., 1989), a number of specific coping strategies have been identified. This section reviews findings from studies that have focused on these strategies, as applied to coping with the stress of being diagnosed with cancer and with its treatment regimen.

Effective Coping Strategy:

These strategies typically include: (a) problem-focusing (solving), (b) planning, (c) information seeking, (d) positive reinterpretation or appraisal, (e) cognitive restraint, (f) confrontation and fighting spirit, (g) seeking
social support, and (h) expressing/ventilating emotions. For the purpose of the following discussion, findings from studies on several of those strategies that share common coping elements and principles are combined.

(a) Problem-Focused/Solving Coping: This category refers to coping efforts directed at problem (e.g., stressful situations) resolution via focused planning and direct action taking. The available literature suggests that this strategy is frequently used by patients with breast and cervical cancers (Heim et al., 1987). It was generally found to have salutary effects on global mental health (Chen et al., 1996), lower levels of depression and anxiety (Mishel and Sorenson, 1993; Morris, 1986), increased vigor (Mishel and Sorenson, 1993), but also was unexpectedly associated with poorer social adjustment (Merluzzi and Martinez-Sanchez, 1997).

(b) Information Seeking: Factor analytic studies of coping scales, administered to people with cancer, have often reported the existence of an information seeking factor (Friedman, Baer, Lewy, Lane and Smith, 1988; Friedman, Nelson, Baer, Lane and Smith, 1990). Empirical findings, however, suggest that information seeking was mostly unrelated to a number of indicators of psychosocial adjustment (vocational, social, familial, domestic, sexual, psychological distress) (Filipp, Klauer, Freudenberg and Ferring, 1990; Friedman et al., 1988, 1990). This factor, however, was found to be positively correlated with active behavioural coping (Nelson et al., 1989), with increased vigor (Stanton and Snider, 1993), and more recently, also with better self-rated psychological adjustment among survivors of breast cancer (Lavery and Clarke, 1996).

(c) Fighting Spirit And Confrontation: Fighting spirit, typically measured by the Mental Adjustment to Cancer (MAC) Scale (Watson et al., 1988), is described as accepting the diagnosis of cancer while optimistically challenging,
tackling, confronting and recovering from cancer (Greer, 1987; Nelson et al, 1989). It has been implicated as a factor contributing to longer survival among people diagnosed with cancer (Greer, 1987; Greer, Morris, Pettingale and Haybittle, 1990, 1992), and, in some studies, inversely related to scores on anxiety and depression (Burgess, Morris and Pettingale, 1988; Schwartz, Daltroy, Brandt, Friedman and Stolbach, 1992; Watson et al, 1991, 1994), emotional or psychological distress (Classen, Koopman, Angell and Spiegel, 1996; Ferrero, Barreto and Toledo, 1994; Friedman et al, 1988, 1990; Nelson et al, 1989; Nelson, Friedman, Baer, Lane and Smith, 1994) and positively related to active-cognitive coping and optimism (Nelson et al, 1989).

(d) **Positive Reinterpretation**: This group of coping strategies has surfaced under a number of different and, at times, slightly variant names, such as, cognitive restructuring, cognitive (re) appraisal, positive growth, focus on the positive, positive thinking, and reframing. This coping, among survivors of cancer, has been studied extensively and is reported to be used frequently (Jarrett, Ramirez, Richards and Weinman, 1992). It has been linked to higher scores on measures of mental health and psychological well-being (Ell, Mantell, Hamovitch and Nishimoto, 1989), positive affect (Manne et al, 1994), lower psychiatric symptomatology (Chen et al, 1996).

(e) **Self-Cognitive Restraint**: Personal control or the ability to use self-restraint is another strategy adopted by survivors of cancer to cope with the stresses evoked by the disease. It was found to be a predictor of positive psychosocial adaptation (Ell et al, 1992). Heim ( ), however, reported that a related coping strategy, that of suppression of competing activities, was associated with poorer reported quality-of-life among survivors of cancer.
(f) **Seeking Social Support**: Another coping strategy directed at defusing stress among people with cancer is seeking support from others. Results have generally demonstrated a positive association between seeking or reporting satisfaction with social support and decreased emotional/psychological distress (Dunkel-Schetter *et al.*, 1992; Jamison, Wellisch and Pasnau, 1978; Mishel and Braden, 1987; Stanton and Snider, 1993), better psychosocial adaptation (Heim *et al.*, 1997) and higher subjective perceptions of well-being, albeit only in a transient manner (Filipp *et al.*, 1990).

(g) **Expressing Feelings**: A frequently researched coping strategy, in both the general population and among survivors of cancer, is expressing or venting emotions. Its use has been linked to higher levels of depression (Keyes *et al.*, 1987), greater psychosocial distress (Quinn, Fontana and Reznikoff, 1986), sickness-related dysfunction (Keyes *et al.*, 1987), and lower perceived quality of life. However, in two studies, this strategy was also related to decreased psychiatric morbidity as measured by the General Health Questionnaire (Chen *et al.*, 1996) and lower mood disturbance; emotional control, alternatively, was associated with mood disturbance (Classen *et al.*, 1996).

(h) **Using Humor**: Only a single study was found that reported the use of humor. Carver *et al* (1993) found in their study that use of humor prospectively predicted lower distress among people with cancer.

3.1.2 **Ineffective (Maladaptive) Approaches**:

These strategies normally refer to mostly maladaptive approaches to coping with stress and crisis. Included are: (a) denial (periodically extended to include selective ignoring, threat minimization and suppression); (b) wishful
thinking or fantasy; (c) problem avoidance or escape; (d) self-criticism or self-blame; (e) social withdrawal; (f) substance/chemical abuse or more generally behavioural disengagement; and (g) fatalism or resignation.

(a) Denial: This extensively researched coping (or defensive) modality implicates cognitions and behaviours that seek lowering of anxiety, minimize threat and alleviate related distressing emotions. It has been found to be prevalent among survivors of cancer (Cooper and Faragher, 1992, 1993; Nelson et al, 1989). It has also been linked to higher levels of psychosocial distress (Carver et al, 1993).

(b) Wishful Thinking: This coping strategy, conceptually related to denial, seeks to diminish negative feelings by resorting to fantasy, diversion and distraction of thoughts (all are forms of mental disengagement) from the problem at hand. This strategy has been linked to affective distress including increased depression and anxiety (Mishel and Sorenson, 1991; Mishel et al, 1991; Parle, Jones and Maguire, 1996). It was also marginally related to higher (increased symptomatology) scores on the GHQ (Chen et al, 1996).

(c) Problem Avoidance and Escape: The existence of this cognitive-behavioural strategy was demonstrated in several factorial analytic studies of people with cancer (Dunkel-Schetter et al, 1992; Jarrett et al, 1992). Poor general psychosocial adjustment including the vocational, domestic, familial and social domains (Heim et al, 1997).

(d) Self-Criticism/Blame: Attribution of blame (e.g., attributing cancer to smoking, poor nutrition etc.) as a coping strategy has been only sporadically studied. Results suggest, however, that it may be associated with:
(a) greater emotional distress (Quinn et al, 1986), (b) decreased general psychosocial adjustment (Heim et al, 1997).

**Social Withdrawal**: As a specific form of the behavioural disengagement coping mode, social withdrawal has been seldom studied, it was, however, found to be linked to increased psychiatric symptomatology (i.e., higher GHQ scores) in a single study (Chen et al, 1996).

**Fatalism/Resignation, Hopelessness and Helplessness**: The coping strategies in this group suggest passive behavioural disengagement from the source of the stress. In this case, the disengagement is giving up hope and willingness to combat cancer. Use of this set of coping strategies has been associated with higher levels of depression and anxiety (Burgess, Morris and Pettingale, 1988; Lavery and Clarke, 1996; Parle et al, 1996; Schwartz et al, 1992).

For five year event free survival a high helplessness/hopelessness score has a moderate, but detrimental effect. A high score for depression is linked to a significantly reduced chance of survival (Watson et al, 1991).

### 3.1.3 Surrender To Fate And Rationalisation:

Two additional coping strategies that defy exact classification into engagement and disengagement coping strategies are: (a) seeking religion and (b) acceptance (of condition, reality, responsibility for condition's management and treatment, future outcomes, etc.). These two strategies suggest both recognition of the eventuality of facing a life-threatening disease as well as limited effort to directly influence its outcome.

**Surrender to religious faith**: Seeking comfort in, or actively relying on, religion and praying for reversal of the disease course has been reported
to be more common among late stage cancer groups. It has been found to be related to: (a) higher scores on mental health and psychological well-being (Ell et al., 1989) and (b) better adjustment to the medical aspects of cancer (Meriluzzi and Martinez-Sanchez, 1997). However, it has also been related to poorer perceived quality-of-life. Searching for meaning in religion was also found to be independent of levels of well-being (as an indicator of an affective state) in a sample of German survivors of cancer (Filipp et al., 1990). Finally, other researchers failed to find any relationship between measures of psychological adjustment and measures of cognitive control including those of prayer and accepting God's will.

(b) Rationalisation: Acceptance of one's condition, including the reality of its implications, learning to live with it, and at times, its irreversible course, has been found to be common coping strategy among people with cancer (Berckman and Austin, 1993; Carver et al., 1993). It has been linked to lower psychosocial distress in one study (Carver et al., 1993). More frequently, though, it has been linked to: (a) higher short-term mood disturbance and state anxiety (Watson et al., 1984), (b) increased depression and anxiety (Parle et al., 1996), (c) increased psychosocial distress (Miller et al., 1996) and (d) decreased feelings of well-being (Miller et al., 1996).

3.2 Proposed Outline Plan For The Present Doctoral Dissertation:

3.2.1 Theme:

Human life is guided by two basic instincts or innate propensities, viz., eros and thanatos. Man loves himself and wants to survive long span. So he
reproduces and loves his progeny. His viability remains dependent on a healthy social life through interpersonal and personal-social relations. The said aspect of man's survival and preservation of his own species has been explained by depth psychologists, after Sigmund Freud, by the concept and dynamics of eros and its expression in the form of different libidinal relationship.

But man is mortal. Death is an obvious destiny of man—a natural consequence of wear and tear of organs which constitute physiological systems. Ordinarily, man does not indulge his propensity for death, rather dislikes a signal for premature death. But there are instances when eros encounters prolonged painful reality, apprehends irrecoverable loss of self-worth in personal-social life, and becomes certain about unsurmountable gloomy future, under those critical stages of life man welcomes thanatos to escape from the world or transforms eros into anxiety to sustain personal invalidity. In our modern social life even, there are incurable diseases which generate such circumstances when the victims become sure of physicians diagnosis and interpret future consequences in the light of his knowledge and experience. For example, thanatosis refers to gangrene—indicating death of part of the body or the first stage in mortification. There are diseases where the victims generate thanatophobia as one of the symptoms. Thanatophobia aggravates death anxiety, depression, morbidity in the way of thinking and perceiving, and interpreting the influence of locus of control to determine the victims' cognitive style.

Oncological researchers have observed often the presence of thanatophobia group of symptoms in the carcinoma patients—particularly when the malignancy or disorderly growth of epithelial cells (which invade adjacent tissue and
spread by the lympholites and blood vessels to other parts of the body) are formally diagnosed and reported to the patient concerned. The above facts have generated few research questions in the mind of the present researcher, as listed below:

(i) Whether thanatophobic ingredients of the cancer patients are caused by the carcinoma as accompanying symptom or they are mere aggravation of psychotic dispositions of those few cancer patients in whom it remained unexpressed?

(ii) Whether thanatophobic ingredients bear a relation with mere chronicity or knowledge of incurability gained by the patient from the failure of different therapies to control the spread of malignancy?

(iii) Whether psychotherapeutic intervention (counselling) play any role to control thanatophobic conditions and improve patient's morale?

(iv) Whether it would be possible to identify certain diagnostic indicators to measure the urgency of counselling and improvement-effect counselling over cancer patients' morale to overcome mental crisis?

Present investigation is planned to probe scientifically in the above enquiry areas.

3.2.2 Survey Of Literature:

Number of published research reports in the area of proposed research before 90s were too scanty. Reviewing them, Sutherland and Weissman (1994) observed that main emphasis was laid down on the coping strategy of cancer
patients. Majority reports agreed upon the mental crisis caused after the knowledge of gloomy prognosis of the physicians. Besides, few of the researchers identified the role of past experience of the victims about incurability of carcinoma, unbearable miseries of progressive degeneration of health conditions of the patients and their social devaluation expressed through social stigma, avoidance, and lack of social support. Temper tantrum and other impulsive behavioural expressions were found present in patients without depression at a higher rate than depressive cancer patients — just on the year of onset of disease (Grassi et al. 1997). They did not confirm positively about any causal relationship between psychosocial variables and carcinogenic depression (ibid).

Feelings of significant devaluation of self-esteem and social inferiority and guilt of social invalidity were found present in most of the cancer patients. Williams (1992) did not recognise psychotic depression as an essential concomitant of carcinoma. It may be considered as a kind of extreme sadness which varies with time and situational crisis. In spite of a variation in their morose feelings they develop ego-defense to protect their self-esteem (Kaplan et al, 1994) — more reality-oriented than fantasy-oriented.

Carcinogenic psychological disturbances often found expressed in thanatophobia and allied mental disturbances and impulsive behaviour (Baider and Kaplan Atara, 1997). Oncologists observed that only a few patients with malign tumors were found in favour of euthanasia; while majority of them were found with thanatophobic symptom and the few with resolute will to cope with the stress of social life with a faint hope to control the progress of disease by surgery chemotherapy, or radioactive exposure on the affected parts (Emanuel et al, 1996; Block and Sillings, 1995).
Reaching the third stage of malignancy the patients desire to die as early as possible while to remain free of mental disturbances during the remaining part of disease-stricken life. The impact of poor quality of life disrupts the patients' cognitive harmony and mental balance helpful for effective and adjusted psychosocial relationships. Baider and Kaplan (1997) in their study with breast cancer patients observed significant positive relationship between intrusion of irrelevant thought and physical distress while insignificant relationship between indifference in social life and physical distress. The issue of carcinogenic personality characteristics yet remains to verification while a few personality correlates like prolonged suppression of mental shock, despair, feeling of loneliness, and uncongenial family relationship were recorded in quite a few carcinomic patients with progressive deterioration. Study of relationships between locus of behavioural control and carcinogenesis yet remain an unexplored area of investigation.

In the light of the above observations and in the event of too scanty unreported local researches it has been referred that carcinogenesis may have an unexplored mental base or certain mental or behavioural correlates are generated during the course and progress of carcinoma in man, which have to be ascertained for the cause of diagnosis and caring for the patients — along with their cognitive and affective dimensions of social life. Accordingly, the present research proposal has been drawn up under the following title of research problem.

3.2.3 Aim, Objective And Title Of The Research Problem:

(i) Statement Of The Problem And Aim Of The Study:

Carcinogenesis and carcinomatosis are pathological states of the body while thanatophobia is a concomitant psychopathological symptom found in
chronic cancer patients, in general — barring the few as exception. The symptom is detected by the attending physician at the clinic following diagnosis and communication of diagnostic report to the patient concerned. Psychopathological symptom in cancer patient is very common in chronic cases — receiving chemotherapy for a longer duration and awaiting for surgical treatment generally. The rate of mental problems is not negligible at the post-surgical supportive treatment, also. Researchers assume here that cancer patients with thanatophobic trait factor carry the risk more in developing the said mental symptoms and sustaining that till the end of the patient's life. But, patients without the said trait factor may develop mental disturbances but under psychotherapeutic counselling can overcome that and restore an adjustment to live long (under effective follow-up treatment).

Survey of relevant research literature while revealing the above facts, have suggested the need for verifying them with local sample and suggest the requirement of psychological services at the cancer clinics for specific purpose. The aim of the present study is to conduct, first time, an enquiry amongst local patients by psychological instruments to understand their mind and the nature of service they require in restoring mental balance and for attaining psychosocial adjustment in the rest part of their life.

(ii) Objectives :

To ascertain :

(i) Whether the expressed psychological disturbances and mental symptoms of breast cancer patient is inherent or situational with reference to the patient's (a) Expressed worries and anxiety and depression, (b) Cognitive coping strategy,
(c) Locus of behaviour control and (d) Interpersonal relations with family members, perceived as family charms?

(ii) Whether the expressed mental disturbances and symptoms of breast cancer patient remain unaltered in different chronic states without any assurance of recovery from illness?

(iii) Psychotherapeutic counselling provides a strong positive support to revitalise the patient's mind to combat with the psychogenic stress of chronic cancer patients, in general.

(iv) Whether the expressed mental disturbances and symptoms of breast cancer patient at post-metastatic stage remain unaltered after supportive counselling?

(iii) Title Of The Problem:

A Cross-sectional Study On The Characteristic Changes In Some Selected Psychological Variables Of Breast Cancer Patients Under Different Stages Of Chronicity.

3.2.4 Research Assumptions:

(With reference to some measurable mental variables)

Hypothesis One: Perceived family charms of a just diagnosed breast cancer patient expresses marks of emotional distress under the impact of her knowledge about the diseased life.

Hypothesis Two: Measures of different psychological variables of a breast cancer patient at different stages of chronicity reveal characteristic changes in her expressed mental disturbances.
Hypothesis Three: Measures of different psychological variables of breast cancer patients at different stages of chronicity are equally benefitted through supportive counselling.

Hypothesis Four: Psychotherapeutic counselling of metastatic breast cancer patients generate desirable changes in the measures of their psychological variables to reflect the benefit of counselling.

N.B.- Measurable mental variables in the present study are: (a) Family charm, (b) Reactive anxiety and depression, (c) Cognitive coping strategy, and (d) Locus of behaviour control.

3.2.5 Method:

(a) Selection Of Venue And Cancer Patients (Sample):

Under the permission of the local hospital authority, altogether 100 willing breast cancer patients will be selected by incidental or purposive sampling method from the outdoor and indoor departments. The patient group will be matched against their period of suffering in the following manner:

(A) Just diagnosed and treatment started;
(B) Diagnosed and receiving treatment over 2 to 5 years; and
(C) Declared not controllable by therapy.

(b) Selection Of Immediate Sibling Of The Patient:

By approaching the patient's family, the patient's immediate junior sibling will be approached to act as respondent of the investigation to collect 'mental disposition' data for statistical
comparison to verify first research hypothesis. One hundred 'immediate sibling' group of individuals will be stratified into subgroups in the manner and procedure followed in case of patient group.

(c) Selection Of Instruments:

Measures will be collected from different groups of selected respondents (for verification of respective Hypotheses) by administering the following instruments:


(d) Steps To Be Followed:

(i) To contact hospital authority for obtaining permission to collect data from hospital outdoor and indoor patients. To
consult hospital records where necessary. To get a suitable place in the hospital for test administration and conduct counselling sessions.

(ii) To prepare a plan and a schedule for data collection from the patients and their siblings; and to print tests and data record sheets.

(iii) To collect data and tabulate them; followed by statistical treatment of data.

(iv) Interpretation of data and verification of hypotheses. Library work for current information, analyse the data, and to draw inferences.

(v) Report writing and compilation of Reference List.

(vi) Presentation of Report in a Public Seminar and submission of the Doctoral Dissertation.

(e) Applied Value Of The Work (Expected):

(i) To throw light on the speculation of a pro-carcinogenic familial mental disposition.

(ii) To ascertain telltale features of some psychological variables reflected in the test scores of chronic cancer patients with diagnostic significance.

(iii) To evaluate the effective role of psychotherapeutic counselling for improving morale and will-to-live of the breast cancer patients by overcoming thanatophobic group of symptoms.