Chapter V

FINDINGS AND CONCLUSIONS
MAJOR FINDINGS OF THE STUDY

This chapter presents the major inferences drawn from the data analysis. It also depicts some workable suggestions which have been derived based on the study inferences.

The researcher would like to initially present the Socio-demographic factors of the respondents. While analysing the age factor having its influence on people being affected by cancer, it is realised that majority of the oral cancer patients, be it male or female, fall in the 61-70 years age group. A high percentage of female cancer patients falls in the age group of 51-60 years, whereas the high distribution of male cancer patients are seen to be in the 61-70 years age group. (Table 4.1)

It is noted that quite a high percentage of the female cancer patients (29.7%) suffers from breast cancer and shockingly majority are widowed or separated (47.2%). It is interesting to note that the patients’ distribution is low in the unmarried category. (Table 4.2).

Considering the educational status of the respondents, it is seen that majority of the female oral cancer patients (50%) and (39%) of pharynx cancer patients are illiterates. Only a very minor percentage, have completed higher level education. (Table 4.3).

It is disheartening to note that a significant part of male patients and a high percentage (79.4%) female patients are unemployed (Table 4.4). However, while analysing the income status of the respondents, it is seen that 47.2% of male patients and 37.6% of female patients earn a monthly income in the range of Rs. 801-1000 (Table 4.5). It is found that majority of the respondents belong to the rural areas (Table 4.6).

It is noted from the analysis that (90.3, oral, 88.5 lung, 87.85 pharynx) of male respondents have smoking habit, and this could possibly be the reason for their illness. In addition, drinking habit is found among majority of the male respondents (Table 4.7).

It is observed that majority of males, females are Hindus, and only minor
percentages are Christians and Muslims (Table 4.8).

It is quite interesting to observe that quite a high percentage of female cancer patients have a cancer history in their family, whereas, comparatively only few of male respondents have a history cancer patients in their family (Table 4.9).

While analysing the current symptoms of the cancer patients, pain is observed to be the predominant symptom. Among the cervix cancer patients 87.5% have stated as pain being the major symptom. It is also noticed that male oral cancer patients and breast cancer patients have many symptoms (Table 4.10).

It is observed from the table that majority of the cancer patients who have been hospitalised for 15-21 days, suffer from cervix cancer, breast cancer or oral cancer. Those suffering from lung cancer or pharynx cancer have been hospitalised for 8-14 days only (Table 4.12).

It is to be noted that pain is the most serious secondary symptom as well among the cancer patients followed by the general weakness, loss of weight, and sleeplessness. Giddiness is the least secondary effect among the respondents (Table 4.19). It is observed that only breast cancer patients use prosthesis and it is mostly artificial breast (Table 4.20).

It is pathetic to note that a high percentage of male patients (50.9%) and 15% of female patients were thrown out of employment, due to their disease. The seriously affected patients are the cervix cancer patients, and they (95.2%) are unable to do the household chores (Table-28). It is observed that majority of the patients have government assistance. It is also true that many of respondents get assistance from family members. Public charity or voluntary organisations are the last source of financial assistance that is being sought by the patients (Table 4.21).

Majority of the respondents opined that family responsibility needs to be shared by other family members (Table 4.22). It is also clearly seen that a good percentage of respondents have stated that they are able to take care of themselves (Table 4.3). It is interesting to note that most female patients get help from their children, whereas the main source of help for the male patients is their spouse (Table4.24).

Majority of the respondents have agreed that their family members show
concern over their health. However, 4.5% of those women suffering from breast cancer have stated that their family members hate them (Table 4.25).

It is noted that majority of the cancer patients covered in this study discuss their health problem with others. Then, 30% of the breast cancer patients do not talk about their illness (Table 4.27). Furthermore, it is understood that a high percentage of the respondents prefer that their spouse/parent/siblings to be as usual and maintain normal life (Table 4.26).

While analysing the major financial changes that took place after the illness, it is noted that majority of patients reported that their family members had to take care of family responsibilities. 10.6% of them stated, that family member had to take up a job after the illness (Table 4.28).

Regarding the plans of the cancer patients, it is realised that majority of them were concerned about their children's marriage, followed by a sizeable percentage who had to plan the educational needs of their children (Table 4.29).

It is to be observed that around 25% of male patients and around 20% of female patients have agreed that they have very good understanding in conjugal life (Table 4.30). It is also noted that a large proportionate of respondents live in joint families (Table 4.32). Moreover around 70% live in families which have 4-6 members, while around 5% live in families which have 10 or more members (Table 4.33).

A high percentage of them receive physical aid, conditional support and financial support from the family members, which is indeed most needed for them (Table 4.34).

It is disheartening to know that few of the respondents do not receive any help from their family members. In point of fact, they interfere in the patients' matter, consider them as burden, curse God for the disease and so on (Table 4.35).

Majority of the respondents take their own decisions concerning their health. However, for some of their spouses take decisions. Parents and elders play little role in decision-making regarding the health matters of the patients (Table 4.36).

It is to be noted that around 50% of respondents have stated that there is no change in the frequency of their relatives visit to their home, while very few have
stated that the frequency of relatives visit to their home has increased (Table 4.37).

It is revealed that considering the nature of the help rendered by the relatives, emotional support stands first, followed by financial assistance, facilitating treatment and assisting during hospitalisation. There is not much statistical differences existing between male and female respondents (Table 4.39).

While analysing the nature of help rendered by friends, it is noted that they help to ventilate the feelings, provide financial support, facilitate financial assistance and stay with them during hospitalisation. (Table 4.40).

It is observed that a very high percentage of male and female respondents, expect emotional support from relatives (Table 4.41). While analysing the sort of help expected from friends, it is seen that around 95% of the total respondents expect their friends to be a good source for ventilation (Table 4.42).

It is observed from the table that the patients receive help during their illness, from three main sources viz. family members, relatives and friends. There are not much statistical differences between the male and female respondents (Table 4.43).

After a visit from the friends or relatives, a minor percentage of the respondents develop destructive feelings, anger or tension. However, quite a high percentage of them feel consoled, relieved, encouraged and even hopeful after relatives/friends visit them (Table 4.44). While analysing the feelings of respondents when others try to cheer them, it is observed that the majority of them feel relieved, some feel dejected of being sick, and still fewer of them feel sad or others get cheered up (Table 4.45).

It is to be noted that a very high percentage of the respondents believe in God and likewise a good percentage of them feel that their prayers are helpful to them (Table 4.46). It is further observed that almost all the respondents like to visit holy places/shrines. A good percentage of them attended special prayers/poojas, sessions for miraculous cure after the disease attacked them (Table 4.47).

It needs special attention here that around 45% of patients opine that the disease is the punishment from God. Only a minor percentage opines that there must be other causes for their disease (Table 4.48).
It is observed that a sizeable percentage of them become more religious after they fall prey to the disease (Table 4.49). It is saddening to note that the respondents have given up the battle for life due to unbearable pain, fear of death, being a burden to the family, failure to fulfil ambitions and the apprehension of social rejection (Table 4.50).

**Findings of ‘t’ test:**

‘t’ test results bring out the significant differences existing between the two groups of study viz. male cancer patients and female cancer patients with reference to various factors.

It is noted from the table that the female patients have more anxiety of death than the male patients do and the difference is statistically significant at 95% level of significance (Table 4.51).

It is found that male patients have higher coping behaviour than the female patients. However, there is found to be no significant difference between male and female patients, which implies that both male and female patients have some coping difficulties (Table 4.52).

While analysing the family burden factors, it is found that generally male patients have more financial burden, routine activities burden, taking care of family leisure, physical health of others and mental health of others, whereas female patients has more burden of family interaction and overall subjective well-being. However, there is found to be no significant difference between the two groups, with respect to these dimensions (Table 4.53).

While studying the ‘social support appraisal’ of the male and female cancer patients, it is noted that the male cancer patients receive higher familial support, support from friends and support from others, than the female cancer patients. This may be due to the importance that is given to men than women in our society (Table 4.54).

With respect to the quality of life of the male and female cancer patients, it is observed that for all the sub-dimensions viz. obj, happy and satisfy, there is no
significant difference between the two groups of study, implying that both the group experience similar quality of life (Table 4.55).

**Anova test Results:**

Anova test brings out the variation existing among the different groups of cancer patients, with respect to various factors. It is found from the table that, the degree of death anxiety varies for different types of cancer patients. Then, the female oral cancer patients suffer from higher death anxiety. There is also found to be statistically significant differences between any two groups of cancer patients, with respect to death anxiety (Table 4.56).

It is further noted from the table that there is significant difference among the different groups of cancer patients with regard to their coping behaviour. Further, breast cancer patients have better coping style.

It is also known that there is no significant difference among the different groups with respect to the family burden dimensions viz. financial burden, routine activities, family leisure, family interaction, physical health of others, mental health of others and overall subjective well-being (Table 4.56).

While focusing on the social support appraisal, it is found that there exists significant difference among the different cancer patients with regard to the social support they receive from family, friends and others. On the other hand, there is found to be no significant differences existing among the different types of cancer patients with regard to the quality of life, i.e. no two type of cancer patients are statistically different.

**Results of Regression:**

Taking the dependent variable ‘Total Death Anxiety’, in relation to various independent variables, it was found that for the male group, ‘Total Social Support Appraisal’ was prominent, as it contributes the highest. The β coeff value indicates negative correlation, which means that as social support appraisal increases, the death anxiety decreases. The f-ratio is found to be at 95% level of significance.
While analysing further, it is seen that for the female group, the independent variable selected was ‘Total quality of life’. Since the $\beta$ coeff is negatively correlated, it implies that as the quality of life increases, the death anxiety decreases. Hence, in order to predict the total death anxiety while considering the female cases, the total quality of life is essential.

While considering the ‘total death anxiety’ for all cases, again ‘total social support appraisal’ was found to be prominent. The $\beta$ coeff is negatively correlated. (Table 4.57).

While studying the stepwise multiple regression results for the dependent variable, ‘Total Family Burden’, the independent variables selected were ‘Total Quality of Life’ and ‘Total Social Support Appraisal’, for the male cases. $\beta$ coeff is negatively correlated. Therefore for predicting the Family Burden, Social Support Appraisal and Quality of Life are important.

With reference to the female group, the independent variable selected was ‘Total Quality of Life’. $\beta$ coeff value is negative, so the independent variable is negatively correlated to the dependent variable.

Considering the Total Family Burden, the independent variables selected were ‘Total Quality of Life’ and ‘Total Social Support Appraisal’, $\beta$ coeff value is negative, implying negative correlation. (Table 4.58). Thus a patient who has better quality of life and social support has comparatively lesser family burden.

While analysing the ‘Total Social Support Appraisal’ for male group, the selected independent variables are Total Quality of Life, Total Family Burden and Total Death Anxiety. It is also noted that quality of life and Family Burden are positively related to Social Support Appraisal and Death Anxiety is negatively correlated to Social Support Appraisal. $\beta$ coeff parameters are reliable since it is significant. However, for the female group, only total quality of life is selected and $\beta$ coeff is positively correlated (Table 4.59). The regression results for Total Social Support Appraisal considering all the cases, reveals that total quality of life, total death anxiety and total family burden are the selected variables, which are essential to predict
the dependent variable social support (Table 4.60).

While analysing the multiple regression results for Total Quality of Life for male cases, the independent variables selected were Total Family Burden and Total Social Support Appraisal. This is also true for the female group and for ‘all’ the cases. (Table 4.61). Thus family and social support are found to influence the quality of life.

The results for Total Death Anxiety for male cases reveals that total number of tests, duration of illness, opinion about the diseases, total social support appraisal, semi urban residence, secondary effect, age and age of onset as the independent variables, are essential for predicting the dependent variable. It is also seen that duration of illness, social support appraisal, and age are negatively correlated, while other variables are positively correlated. (Table 4.62)

While considering the female cases for the same dependent variable, it is seen that, opinion towards treatment, opinion about the disease, only Christian, total number of tests, age and age of onset are the selected independent variables, required for predicting this dependent variable. Except for age and opinion towards treatment, all independent variables are positively correlated and β coeff are reliable parameters.(Table 4.63)

While considering the total death anxiety for all cases, the selected independent variables are only male, opinion towards treatment, opinion about the disease, duration of illness, total number of test, secondary effect, age, age of onset primary effect, History of cancer in the family and only rural, which are all essential for predicting the dependent variable. There is found to be both negative and positive correlation among the independent variables. (Table 4.64) This means that death anxiety decreases when the opinion about the treatment improves, when the duration of illness is longer and with increasing age. The male patients tend to report less death anxiety. The increase in the number of tests used, secondary effects, younger age of onset, and history of cancer in the family increases the experience of death anxiety

While studying the coping behaviour for female group and for all cases, the independent variable selected was ‘history of cancer in the family’. This is imperative predicting the dependent variable β coeff is positively correlated in both cases.(Table
4.66). Thus, patients with a history of cancer in the family cope better with their own illness.

The regression results for ‘Total family Burden’ depicts the independent variables to be Total Quality of Life, Total Social Support Appraisal, having any debt/loan, religious practice and only nuclear family, all of which are essential for predicting the dependent variable. $\beta$ coeff is seen to be significant for the female group, the independent variables selected are total quality of life and education & both are negatively correlated to the dependent variable. (Table 4.67). And so the experience of burden by the family decreases with better quality of life and education of the patient and increases with poor quality of life and lower education.

The analysis further depicts that for ‘Total Family Burden’ for all cases the independent variables selected are total quality of life, religious practices, total social support appraisal, only semi urban and only nuclear family. All the variables, except the quality of life are positively correlated to the dependent variable. $\beta$ coeff is significant. (Table 4.68) This means that nuclear families experience higher levels of burden. And also as the burden increases, the families engage themselves more and more in religious practices.

For total social support appraisal for the male group, the independent variable selected are Total Quality of Life, Total Family Burden, primary effect, only Muslims, only married and only semi urban. Excepting only Muslims and only semi urban, all other variables are positively correlated. For the female group, the independent variables selected are total quality of life and history of cancer in the family.

$\beta$ coeff is positively correlated for total quality of life, whereas negatively correlated for history of cancer in the family. (Table 4.69)

Considering all cases for total social support appraisal, the independent variables that are prominent are Total Quality of Life, only female, only Muslims, history of cancer in the family, total family burden and primary effect which are all essential for predicting social support. (Table 4.70)

The multiple regression results for total quality of life for male group shows that the independent variables selected in the equation are total family burden, total
social support appraisal, only Muslims, total number of tests and treatment systems. Also seen is that as family burden increases, the quality of life decreases. Then, the other independent variables are positively correlated to the quality of life. (Table 4.71) 

Considering the female group only, the independent variables selected are total family burden, total social support appraisal, only unmarried, only nuclear family and secondary effect, which are imperative for predicting the dependent variable. $\beta$ coeff is significant (Table 4.72). Taking the same dependent variable for all cases, the independent variables found prominent are total family burden, total social support appraisal, only Muslims, number of members in the family, religious practice, primary effect and only unmarried. It is observed that family burden, number of persons in family, and religious practices are negatively correlated, whereas the other variables are positively correlated. $\beta$ coeff is significant and F-ratio is significant at 95% level of significance. (Table 4.73)

**Correlation Results:**

While analysing the correlation between the independent and dependent variable, taking into consideration the male group only, it is seen that opinion about the disease and death anxiety are positively correlated which implies that as opinion about the disease gets clear, death anxiety increase or vice versa, also number of tests and death anxiety are positively correlated, which implies that as the number of tests increases, death anxiety also increase or vice versa. Number of secondary effect and death anxiety are also positively correlated. (Table 4.74).

While Analysing the female group only, it is seen that history of cancer in the family and coping behaviour are positively correlated, which implies that when there is earlier cancer history in the family, coping behaviour are higher. Also as the number of hospitalisation increase, death anxiety also increase, further as the number, of secondary effect increase, death anxiety also increase. (Table 4.75)

While considering all the cases, it is observed that as the history of cancer in the family increase, the social support appraisal decreases. There is seen to be a high level of significance. Also as they take other systems of treatment more, death anxiety also increase or vice versa. (Table 4.76)
While finding out the correlation among the dependent variables for the male cases, keeping one variable constant, it is noted that as quality of life increases, the family Burden decreases, also as quality of life increase, social support appraisal also increases. (Table 4.77)

Considering the female groups, here again we see that as quality of life increases, family burden decreases. Likewise, there is positive correlation between quality of life and social support appraisal. The correlation is highly significant at 98% level of significance. (Table 4.78)

Taking into account all the cases, it is observed that, quality of life and family burden are relatively correlated, implying that as quality of life increases, family burden decreases or vice versa. There is also positive correlation existing between quality of life and social support appraisal, and the correlation is highly significant at 98% level of significance (Table 4.79).

**Discussion & Suggestion:**

It is found that cancer history in family is found to be more prevalent among female members like mother, sister or daughter. It is a fact that genetic influences have long been suspected for the disease occurrence. There is probably a complex interrelationship between hereditary susceptibility and environmental carcinogenic stimuli in the causation of a number of cancers. It is therefore suggested that on identifying cancer cells in a person, the female members in the family could be given special attention for identifying traces of cancer cells. This would enable early diagnosis and possible prevention of the disease.

A majority of women suffer from breast cancer (46.1%). Breast cancer is one of the commonest causes of death in many countries, including India as well. The risk is high in those with a positive family history of breast cancer, especially if a mother or sister developed breast cancer when premenopausal. Hence, all women should be encouraged to perform breast self-examination, as it is known that breast cancers are, more frequently found by women themselves than by a physician during a routine examination. Women under 35 years of age should not exposed to X-rays unless they
are symptomatic or with a family history of early onset of breast cancer.

The study reveals that smoking habit is widely prevalent among the male patients (89%). Therefore, ambitious programmes need to be developed country wide to eradicate tobacco smoking by the year 2000. Government, service organisations and even industries should prohibit smoking during working hours. Smoking should not be done even in the vicinity of the work place.

The study results reveal that pain is the major symptom being found among the patients, irrespective of the type of cancer. Any physical pain is intensified by mental anguish, and if the latter can be assuaged, the physical pain can become tolerable. Application of sound common sense, compassion and understanding will be helpful to reduce the pain. Mental pain requires skilled counselling and empathetic approach towards the patient.

It is found that quite a sizeable percentage of the patients have been thrown out of employment after the disease. It is indeed a pathetic situation. Employers need to realise that cancer patients need their support and assistance. They will have to be given psychological and emotional support. The least the employers can do is to keep them in employment, provide them with sick leave and offer some sickness benefit.

It is realised that few breast cancer patients have reported that their family members show hatred towards them. To a woman, the breast emphasises her essential femininity and as a consequence emotional influences are very strong. Hence, it is the duty of the family members to reassure her and provide necessary support. Her husband should continue to love her and reassure her continuously. The patients must be treated as a whole person with a body, mind and soul.

Generally cancer patients will be very frightened and will develop feelings of depression, frustration, anger, fear, loneliness, anxiety and so on.

Study results show even destructive feelings. Hence, it is the duty of the family members, friends and relatives to render physical, mental and emotional support to the patients.

One must be sympathetic without being sentimental, be practical without being hard hearted and must be able to impart hope when all seems black, one must be
willing to listen and one must know when to keep silent and when to reassure. They must understand their problems, fears, troubles, hopes and expectations and provide required assistance. Friends also must be sympathetic and lend a helping hand. Counselling will form an essential feature of support services. Experts can be involved to render counselling services for the patients.

A high percentage of the patients believe that their disease is the will of God. These people must be told about the causes of their ideas and the major sources through which it attacks a person. Possibly they lack the knowledge and awareness about the ill effects of alcohol, tobacco and such other things and continue the habit which causes the sickness. Hence, preventive education will have to be organised, so that people know about the consequences of their habit. Prevention of cancer really involves education and an understanding of the disease. The overall aim of public education should be to create by all ethical means a climate of opinion that is both informed and vigilant and not dominated by exaggerated fears.

It is also seen that female patients have more death anxiety than male patients. But then, the fear of death is common for all patients. These people require someone to sit with them, listen to their expressions of feelings and thoughts. Care, understanding and compassion of the very highest standards need to be provided to them. They will have to be made to face the reality in life and to accept their illness. Strategies will have to be adopted for their rehabilitation and normal functioning.

It is inferred that as the quality of life increases, family burden decreases. It is required that the patients is allowed to have a good quality of life that is soothing to his physical and mental well-being. It is the responsibility of the family members and friends to provide a healthy quality of life for the patients.

Weisman and Worden (1975), Vochan (1979) and Wortman Dunkell Schetter (1984) found that emotional support was helpful when it came from family members and they also found that social support at the time of diagnosis was associated with less emotional distress and longer duration of life.

The need of the hour is to create public awareness about the hazards of smoking through mass media. The youth and school children are to be given special
attention in these educational programmes. Park and Park have stated that curtailment of smoking must be an essential part of national health policy.

It requires the combined efforts and co-operation of family members, friends, relatives, employers, neighbours and all those close to the patient to extend their understanding, affection, care and concern for the patient. They will have to continuously reassure the patients, and be supportive to them. It largely lies in the hands of the close ties to promote the physical and mental well-being of the patients; to lessen or to eliminate the fear, death anxiety, frustrations, depression, negative attitude and destructive feelings. They have to seed healthy outlooks, happiness, acceptance and normally into the minds of these sufferers.

Suggestions for future studies:

It is felt that much lies to be explored in this area, especially in the Indian context and hence many more studies can be carried out which will help in bringing out explanatory models. The Researcher puts forward few suggestions, which given an opportunity, would be areas of interests for further studies.

1. The perceptions of stress, coping behaviour and quality of marital life of the cancer patients and their spouses could be studied.

2. Studies focussing on the mental health aspects and needs of the patients as well as their spouses should be planned and carried on more extensively.

3. Prospective studies on the etiology, especially the psychological factors, carried out on a large scale, would throw more light on the systems view of etiology of the illness.

4. The impacts and emotional disturbances faced by the patients’ children and their subsequent behavioural patterns could form an important study.

5. Standardised instruments, specifically for this interest group, should be developed.

Conclusion:

Cancer is as old as history itself, but unhappily there has always been attached to it the implied stigma that death was an inevitable consequence. This has led to the awful permission which still surrounds the disease today. Cancer is an emotive word,
for to many, it spells grief, despairs, bewilderment, fury, frustration and indeed the whole range of human emotions. A cancer patient is not merely an individual with a diseased body, he is also a person with a throbbing heart, a thinking mind, a stirring soul and one who lives in a small world of his own, surrounded by his family and friends. He has a physical disease that can be treated by the doctor, but he also has attitudes and aptitudes, interests and instincts, hopes and dreams of the future - which are all affected by his malady.

Hence, it is imperative that all who have close contact with cancer patients should fasten out their own general philosophy - to be sympathetic, understanding, caring, accepting, willing to help and at the same time should be practical, not to keep the patient in the dark, not to treat him as an outcast, or be hardhearted.

The patient will have to be made to understand his disease or disability, regain confidence and be inspired, always making sure that fears and anxieties are dispelled and that social problems are solved. Also rehabilitation for the cancer patient, is a team effort and requires the outstretched arms of the family, friends, relatives, doctors, physiotherapists, social workers, counsellors and others to help and support him. It needs to be remembered that total patient care and understanding is the essence for providing a better psychological and social adjustment of cancer patients.

The functions of oncology social workers fall into three broad categories: Clinical Practice, Education, and Research. Oncology social workers traditionally have assisted patients in coping with the stresses of cancer diagnosis, treatment, rehabilitation, and terminal illness. A major role of the oncology social worker is that of a therapist and counsellor. Here the primary goal of the social worker is to help patients and family members to adapt to the stresses of the diagnosis and treatment within today's complex health care procedures. To achieve this goal, the social worker relies on a broad range of counselling modalities and therapeutic techniques: individual, group, and family therapy; education; behaviour modification; crisis intervention; supportive techniques, and insight oriented interventions.

A social worker would be ill fit for this role unless he or she has the adequate knowledge level. Social worker in oncology should be able to assess the various
psychosocial issues including the patient's emotional state. These issues are different in gravity and quality in the various phases of the illness - from the stage of diagnosis, through treatment induction, treatment side effects, treatment termination, survivorship, recurrence, research treatments, terminal illness, and bereavement.

Psychosocial intervention programs can be developed and their effectiveness enhanced for it has been proved in the course of this research that programs and practices, with close observation and analysis of the various psychosocial issues produce significant positive changes in the patient and his/her family.

The present study, it is hoped, will add to the existing knowledge that we have about the psychosocial issues in oncology and prove beneficial to the social work professional in the field of psycho-oncology.