

COPING WITH BLADDER CANCER

by

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A Master's Research Project

Presented to

The Oregon Health Sciences University

School of Nursing

In Partial Fulfillment of

The Requirements for the Degree of

Master of Science in Nursing

June 8, 1990

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## ACKNOWLEDGMENTS

The pursuit of graduate education would not have been possible without the support and encouragement of my husband, Richard. The successful way in which he managed to live with cancer gave me added insight into coping with cancer. Special thanks is due my mother, Helen Alford, who assumed many child care responsibilities following Richard's death in March.

I would like to express my appreciation to the staff of the Roseburg Veterans Affairs Medical Center for their support in the completion of this project. Members of the nursing service and medical center research committees provided feedback on the proposal and expedited the approval process. One of my co-workers, Martha Southern, did an outstanding job designing the research instruments. Data collection progressed smoothly due to the cooperation of the nursing and clerical staff on the surgical unit.

This project would not have been possible without the guidance of my advisor, May Rawlinson. The readers on my committee, Katherine Crabtree and Paula Morton, offered

excellent suggestions throughout the research process.

I would also like to thank the veterans with bladder cancer who participated in the study. It was while caring for them that I first became interested in learning more about how they cope with their disease. They have taught me much about living with cancer.

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## CHAPTER I

### INTRODUCTION

Decreased funding to Veterans Affairs Medical Centers (VAMC) and the current nursing shortage has meant fewer nurses to care for cancer patients requiring increasingly complex levels of care. In the past nurses had time to spend with patients to evaluate the effects of cancer on their lives and to assist them in coping with the crisis of cancer. Now, VAMC nurses rush from task to task caring for patients' physical needs with little time available to care for their psychological ones. Nurses need ways to efficiently use their time. By having a means of effectively evaluating patients' problems and coping methods, nurses would be better able to discharge patients with the skills and resources necessary to adjust to the day-to-day changes of living with cancer.

That cancer has a significant impact on the patient's life is well known, yet the majority of research on this aspect of cancer has focused on the early and terminal phases of the disease (Chekryn, 1984). In their study of



the effects of cancer on patients' lives, Mages and Mendelsohn (1979) suggested that research on the psychosocial aspects of cancer should focus on delineating the sequence of issues in the disease and identifying the methods used to cope with them. As Weisman (1979) wrote, "For the cancer patient and family, there is nothing of greater magnitude besides cure itself, than how to cope . . . through weeks, months, and even years" (p. XV). The ways people cope have been the focus of work by Lazarus (Folkman & Lazarus, 1980, 1985; Lazarus, Averill, & Opton, 1974), Moos (Billings & Moos, 1981; Holohan & Moos, 1987; Moos, Cronkite, Billings & Finney, 1984; Moos & Schaefer, 1984), and others (McCrae, 1984; Parkes, 1986; Pearlin & Schooler, 1978; Scott, Oberst, & Bookbinder, 1984). Incorporating the evolving theory into nurses' practice is slow to take place.

It is important to study the overall impact that cancer has on a person's life and to identify the coping mechanisms that are used to manage any problems. The long term goal of such a study is to enable nurses to better assess their patients so that they can develop appropriate interventions for those whose coping methods are counterproductive, while encouraging and supporting those who are coping well.

### Review of Literature

Included is a review of the literature on coping in general, coping with chronic illness, coping with cancer, and coping with bladder cancer. The coping process, factors that influence coping, and coping strategies are discussed as part of general coping theory. Studies of coping with various chronic illnesses are discussed in relation to factors influencing coping, coping strategies, and coping outcomes. The third part of the review of literature is a discussion of coping with cancer; the impact of the disease, coping strategies, and the phases of the disease. The course of bladder cancer is discussed in the final part.

### General Coping Theory

Growing out of research in the field of stress, investigations of coping have increased in the past two decades. While early studies focused on coping as a result of an individual's coping style or traits (Cohen & Lazarus, 1973; Lazarus et al., 1974), later work has described coping as a transactional process influenced by personal and situational-environmental factors (Lazarus & Folkman, 1984). These factors affect the specific strategies an individual uses to cope with a stressful event.

Lazarus's definition of coping is used in the current

study. He defined coping as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 141).

Coping process. Coping is described as a dynamic process in which an individual uses cognitive appraisal to cope with a stressful situation (Lazarus et al., 1974). The first component of the process is primary appraisal in which an individual determines whether a situation is benign, insignificant, or stressful. If stressful, the situation is appraised as to whether the stress is a harm/loss (damage has already occurred), a threat (anticipated harm or loss), or a challenge (anticipated opportunity for growth, mastery, or gain). Secondary appraisal refers to the evaluation and selection of coping strategies to be utilized. Reappraisal refers to a change or redefinition of the original perception of the stress.

In two studies that assessed the influence of losses, threats, and challenges on the choice of coping strategies, McCrae (1984) found significant variation, depending on whether stress was appraised as a challenge or a harm or threat. Folkman and Lazarus (1985) found significant changes in emotion (used as a measure of appraisal) and coping across three stages of a midterm examination.

Factors influencing coping. Two categories of factors have been identified that influence an individual's appraisal of stress (Lazarus & Folkman, 1984). Person factors include an individual's commitments, beliefs, and coping experiences, as well as such things as age, gender, and socioeconomic status. Situational-environmental factors include aspects of the stressful situation itself, such as uncertainty of outcome and timing in the life cycle, and characteristics of the environment, such as social and material resources. Person factors interact with situational-environmental factors to affect the appraisal of stress.

In a study of 135 first-year nursing students, Parkes (1986) found that personality and environmental factors influenced the choice of coping strategies used in stressful episodes. Holahan and Moos (1987) found that sociodemographic factors, personality dispositions, negative life events, and family support made a significant contribution to predicting the type of coping used in a sample of over 400 adults and a sample of over 400 patients with unipolar depression.

Coping strategies. The classification of coping strategies that are evaluated and selected during secondary appraisal has been the focus of several studies. Lazarus, Averill, and Opton (1974) initially divided coping into two

modes of expression--direct action and intrapsychic. Later work by Lazarus and his colleagues classified coping into two categories: problem-focused, those strategies directed at managing or altering the problem; and emotion-focused, those strategies directed at regulating the emotional response to the problem (Folkman & Lazarus, 1980). Factor analysis of their coping scale revealed four modes of coping: direct action; inhibition of action; information seeking; and intrapsychic or cognitive coping (Lazarus & Folkman, 1984). In a later study (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986), factor analysis of their coping checklist produced eight forms of coping: confrontive; distancing; self-controlling; seeking social support; accepting responsibility; escape-avoidance; planful problem solving; and positive reappraisal.

Pearlin and Schooler (1978) identified the following categories of coping: 1) responses that change the situation; 2) responses that alter the meaning or appraisal of the stress; and 3) responses intended to control distressful feelings. Billings and Moos (1981) developed similar classifications. They divided coping strategies into: 1) active-behavioral strategies, actions taken to deal directly with the situation; 2) active-cognitive strategies, attempts to manage the perception of the stress; and 3) avoidance strategies, those used to avoid

confronting the problem.

Coping is a dynamic process in which person and situational factors interact to influence how an individual initially determines the significance of an event, then selects strategies to cope with the stress, then evaluates the effectiveness of the strategies or redefines the significance of the stress. While the above research involves coping with the stresses of life, other studies have focused on coping with illness.

#### Coping with Chronic Illness

Studies of coping with illness have included how individuals cope with chronic illness in general, as well as how they cope with specific illnesses. These studies will be discussed in relation to factors that influence coping, coping strategies, and coping outcomes.

Factors influencing coping with illness. In describing how individuals cope with physical illness, Moos (Moos & Schaefer, 1984) separates physical and social environmental factors, as described by Lazarus, from the situational factors of illness. Situational factors related to illness include such things as physical symptoms, the clinical stage of the disease, and the success or failure of treatment. Situational factors influence how an individual appraises the stress of illness

and selects the strategies used to cope with the illness.

Benner and Wrubel (1989) emphasize the importance of examining the situation of illness. They state:

Health and illness are always situated in the person's life. When an illness is extreme, it temporarily becomes the whole situation, and the other aspects of the person's life may fade into the background. In contrast, the illness may be defined totally in response to another situation, such as a major performance or other life event. (Benner & Wrubel, 1989, p. 80)

Factors that influence how individuals cope with illness was the focus of a study by Feifel, Strack, and Nagy (1987). The use of one of three major coping strategies (confrontation, avoidance, or acceptance-resignation) was assessed in samples of male patients with cancer (N = 74), heart disease (N = 77), and non-life-threatening illness or disability (N = 72).

Responses on a variety of self-report measures indicated that such factors as socioeconomic status, personality traits, and severity of the illness influence the choice of coping strategies. In a series of studies, Viney and Westbrook (1984) found that the choice of coping strategies varied, according to the type of illness, and whether or not the patient was

hospitalized.

Coping strategies. Using measures derived from the work of Lazarus, Moos, and Pearlin and Schooler, other investigators have studied coping in hypertensive and emergency room patients (Jalowiec & Powers, 1981), patients on hemodialysis (Baldree, Murphy, & Powers, 1982), patients undergoing coronary artery bypass grafting (King, 1985), survivors of burn injury (Roberts et al., 1987), patients with functional disabilities (McNett, 1987), and patients with hypertension (Powers & Jalowiec, 1987). The results of these studies indicate that individuals use a mixture of strategies to cope with the stresses of illness. The selection of coping strategies is part of the coping process; specific strategies are not inherently adaptive or maladaptive. It is only by evaluating the outcome that one is able to determine whether or not a strategy is effective.

Coping outcomes. Different methods have been used to evaluate the effectiveness of coping with illness. Five criteria for determining coping effectiveness were identified by Miller (1983). They are: "1) uncomfortable feelings (anxiety, fear, grief, or guilt) contained, 2) hope generated, 3) self-esteem enhanced, 4) relationships with others maintained, and 5) state of wellness (self-actualized well-being) maintained or improved"



(Miller, 1983, P. 27). No other studies of coping have been reported using these criteria.

The Psychosocial Adjustment to Illness Scale (PAIS) was used as an outcome measure in a study of coping with burn injury (Roberts et al., 1987). Subjects' responses on the PAIS were compared to the coping methods employed in Powers and Jalowiec's (1987) study of hypertensive patients.

The McNett Coping Effectiveness Questionnaire (MCEQ) was used in a study of coping with functional disabilities (McNett, 1987). Construct validity of the MCEQ was evaluated by comparing the responses on the MCEQ with subjects' response to a single item rating their coping effectiveness. The use of a single item such as, "How well do you think you are coping with your illness?" was used in studies of coping with chronic illness (Feifel et al., 1987) and coping and mental health (Aldwin & Reveson, 1987).

In sum, a number of factors influence the variety of coping strategies that are used to cope with a chronic illness. Among the most important factors are those related to the situation of illness, such as, physical symptoms, stage of disease process, and response to treatment. Outcome measures from simple to complex have been used to evaluate the effectiveness of coping with

chronic illness.

### Coping with Cancer

Cancer is one of the most dreaded diseases in our western culture (Benner & Wrubel, 1989). Advances in cancer treatment have increased the life span of many of those diagnosed with the disease, so that they must make long-term adjustments to living with cancer. In this section, research on the impact of cancer, coping strategies used, and the psychosocial phases of the disease are discussed.

Impact of Cancer. Cancer and its treatment have a major impact on the life of the patient. The multifaceted effects of the disease can have behavioral, cognitive, and affective consequences (Meyerowitz, Heinrich, & Schag, 1983). Research has indicated that cancer patients experience emotional distress, physical symptomatology, alteration in the pattern of daily life, and/or worry over progression of the disease and death.

Gotay (1984) used the COPE interview format developed by Weisman and Worden (1976-77) to study women with early stage cervical cancer or precancer (n = 42) and women with advanced stage breast or gynecological cancer (n = 31). She investigated the problems encountered, the coping mechanisms used, the relationship of specific problems to

coping style, problem resolution, and variation of problem, coping, and resolution at different stages of the disease. Among the most frequently occurring problems were: fear of cancer diagnosis, progression or recurrence; general emotional disturbances; future ability to have children; effect of illness on job; restrictions on activities; side effects; and worry about their family's future. The ranking of all problems, except for highest ranked fear of cancer, varied according to stage of disease.

The COPE interview format was also used by Oberst and James (1985) in their study of 40 newly diagnosed cancer patients who had had surgery for cancer of the bowel or genitourinary system. The majority of the sample was male (77%); and the mean age was 57 years. The investigators collected data at discharge and 10, 30, and 60 days after discharge. Twenty-six of the patients were interviewed 90 and 180 days after discharge. The problems the patients experienced were coded into the following categories: life style disruption; symptom distress; uncertainty; emotions; roles; identity; stigma; information; health care systems, and finances. Symptom distress was the area of most concern, with disruption of life style and uncertainty being the other areas where frequent problems occurred in their sample.

The Cancer Inventory of Problem Situations (CIPS) was

used to compare the number and severity of problems experienced by a group of cancer patients (n = 32), cardiac patients (n = 32), and healthy controls (n = 32) (Schag & Heinrich, 1986). All subjects were veterans, and groups were matched on the demographic characteristics of sex, age, ethnicity, occupational background, and education. Cancer patients experienced more problems ( $F = 10.34$ ,  $p < .001$ ) and rated them as more severe ( $F = 21.68$ ,  $p < .001$ ) than both the cardiac patients and healthy controls.

A study of 130 ostomy patients, many of whom had cancer, (Turk, Sobel, Follick & Youkilis, 1980) identified six categories of problems: technical management; occupational adjustment; social adjustment; marital/sexual adjustment; family adjustment; and emotional adjustment. Subjects were asked to indicate whether the items were current problems, former problems, or anticipated problems, as well as rate the intensity and duration of the problem. Among their findings were that 40 percent reported a decrease in frequency of sexual activity, and 11 percent reported an increase in the frequency of sexual activity. They also found that 31 percent reported a decrease in social activities, while 39 percent reported an increase in social activities.

Other reports in the literature have demonstrated considerable variation in the type and severity of the

impact of cancer (Meyerowitz, et al., 1983). While various person-related and disease-related factors have been suggested as contributing to these differences, the methods individuals use to cope are an important determinant to the differences in the ways patients adjust to living with cancer.

Coping strategies. To study the coping methods used by people with cancer, Weisman and Worden (1976-77) developed a scale consisting of 15 broad coping behaviors. Subjects' responses on interviews were classified according to these general coping strategies which the investigators call COPE. The 15 strategies are:

- 1) Seek more information about the situation (rational-intellectual).
- 2) Talk with others to relieve distress (shared concern).
- 3) Laugh it off; make light of situation (reversal of affect).
- 4) Try to forget; put it out of mind (suppression).
- 5) Do other things to distract self (displacement).
- 6) Take firm action based on present understanding (confrontation).
- 7) Accept, but find something favorable (redefinition).
- 8) Submit to and accept the inevitable (fatalism).

- 9) Do something, anything, however reckless, impractical (acting out).
- 10) Negotiate feasible alternatives (if X, then Y).
- 11) Reduce tension by drinking, overeating, drugs (tension reduction).
- 12) Withdraw socially into isolation (stimulus reduction).
- 13) Blame someone or something (disowning responsibility).
- 14) Seek direction from an authority and comply (compliance).
- 15) Blame yourself, sacrifice or atone (self pity).

The investigators assessed total mood disturbance, using the Profile of Mood States; predominant concerns, using an inventory; coping methods, using the COPE inventory; problem resolution, using a 4-point scale; and vulnerability, using an index rated by the interviewer. Initial assessments were made at the time of diagnosis. Three follow-up assessments were made at 4 to 6 week intervals. When responses on COPE were compared to vulnerability, problem resolution, and total mood disturbance, it was found that "good" copers used confrontation, redefinition, and compliance strategies.

The 120 subjects represented 5 different types of cancer; lung (n = 23), malignant melanoma (n = 19), breast

(n = 37), colon (n = 23), and Hodgkin's disease (n = 18). The pattern of the subjects' vulnerability, or emotional distress, over time varied according to the site of cancer.

An inductive approach was used by Mages and Mendelsohn (1979) to determine the effects of cancer on patients' lives. Intensive, semi-structured interviews were conducted with a heterogenous sample of 66 subjects. Follow-up interviews were done 6 to 12 months later with 21 subjects. The investigators found three basic modes of coping with cancer: 1) techniques to minimize distress; 2) active attempts to deal with the issues; and 3) turning to others.

In her study of coping during early and late stages of cancer in women, Gotay (1984) found that taking firm action, seeking more information, talking to oneself, finding something favorable about the situation, talking to others, and praying were the most frequently used strategies. The ranking of the strategies were different for the early and late stage groups.

Psychosocial phases of cancer. During the course of the disease, the impact of cancer and the methods of coping change. Weisman (1984) has described four phases in the clinical course of the disease during which many cancer patients find it most difficult to cope.

Existential plight is the phase beginning with the

impact of diagnosis and continuing until the end of initial treatment. It is during this period that cancer patients first confront their own mortality and learn to deal with the ramifications of treatment. Phase two, accommodation and mitigation, begins when patients return to a routine. Adjustments are often necessary as they resume the activities and roles that are part of everyday life. They must cope with uncertainties regarding the progress of the disease and residuals from the treatment, as well. Recurrence and relapse is perhaps the most discouraging period for a patient to face. Hope for a "cure" is no longer possible. During deterioration and decline, palliation and not cure becomes the purpose of treatment. Patients become more dependent on others, attempt to complete unfinished business, and focus more on themselves and their immediate family and less on the outside world. There is a lack in the literature of empirical studies of the coping strategies used by cancer patients in designated phases of their disease.

Cancer is not a single disease entity. Prognosis and treatment regimens vary considerably depending on the site of cancer. Gotay (1984) suggested that a clearer understanding of coping with cancer can be found by focusing on specific sites of cancer.



### Coping with Bladder Cancer

Bladder cancer accounts for over 45,000 new cases of cancer each year and is the cause of 20,000 deaths annually. The majority (33,000) of new cases are found in men (Silverberg & Lubera, 1987). At the time of diagnosis, cystoscopic examination reveals the extent of the disease within the bladder and pathological examination determines the depth of tumor invasion into the bladder wall. The treatment for most superficial bladder tumors consists of transurethral resection of the tumor followed by a 4 to 6 week course of intravesical chemotherapy to reduce the likelihood of recurrence. Patients are then followed by cystoscopic examination as often as every 3 months with treatments repeated as necessary. For those bladder tumors that are found to be invasive at the time of diagnosis or those that later become invasive, the primary treatment is partial or total cystectomy, pelvic lymph node dissection, radiation therapy, systemic chemotherapy, or a combination of these modalities (Gray, 1986; Soloway, 1986).

Individuals with cancer of the bladder must cope with the discomfort of treatment and frequent cystoscopic examinations, the possibility of recurrence and progression of the disease, potential change in their sexual functioning, the prospect of mutilating surgery, and the possibility of death. In the only study of coping with

bladder cancer the present investigator could locate in the literature, Scott, Oberst, and Bookbinder (1984) found that their 30 subjects had incorporated periodic cystoscopic examination into their lives with minimal distress. No information was obtained on coping with other aspects of the disease.

In summary, coping with an illness such as cancer is a dynamic process in which person and environmental factors interact with the situational factors of illness to influence the way an individual appraises stress and selects coping strategies that lead to either satisfactory or unsuccessful adaptation. For a person with cancer, coping requirements change according to the phase of the disease. The single study found in the literature of coping with bladder cancer focused only on the stress of periodic cystoscopic examination (Scott et al., 1984). There remains a need for studies that identify the spectrum of problems faced by patients with specific types of cancer along with the kinds of coping strategies they have found to be useful in dealing with these problems.

#### Conceptual Framework

The conceptual framework for this study is based on the work of Lazarus and Moos. Coping is a dynamic process in which an individual uses cognitive appraisal to cope

with a stressful situation (Lazarus et al., 1974). Initially an individual determines the significance of a stressful event, then selects strategies to cope with the stress, then evaluates the effectiveness of the strategies or redefines the significance of the stress. Three categories of factors influence a client's appraisal of the stresses of illness (Moos & Schaefer, 1984). Demographic and personal factors, such as age, sex, and personality; social and physical environmental factors, such as social support, economic resources, and distance from health care services; and situation factors, such as site of cancer, length and severity of illness and type of treatment, interact to affect how an individual views the situation and selects the strategies to cope with the stress of cancer.

#### Purpose of the Study

The purposes of this study were to identify the problems encountered by men with cancer of the bladder and to identify the coping strategies they use. A description of some person, environmental, and situation factors are presented. However, due to the small sample size, these variables were not stratified and examined for their influence on coping. The study did control for such characteristics as age, sex, type of cancer, and type of

treatment facility through the homogeneity of the sample and the site of data collection.

Several questions were posed in order to better understand how men cope with cancer of the bladder. The research questions investigated are as follows:

1. What problems are most frequently experienced by men with bladder cancer?
2. What coping strategies are most frequently used by men with bladder cancer?
3. What is the relationship between the type of problem encountered and the choice of coping strategy?
4. What is the relationship between perceived efficacy of coping and the choice of coping strategies?

## CHAPTER II

### METHODS

#### Setting and Subjects

The study was conducted at a rural Veterans Affairs Medical Center in the Northwest with one staff urologist. Currently there are 64 patients with cancer of the bladder being followed by the urology service. Their ages range from 39 to 90 ( $M = 69.7$ ,  $SD = 9.1$ ). All but one of the patients are male. Following pathological confirmation of non-invasive cancer of the bladder, patients are admitted for transurethral resection of the bladder tumor (TURBT). Patients then usually receive a 6-week course of intravesical chemotherapy on an outpatient basis. Cystoscopic examinations (also as outpatients) occur every 3 months for the first 2 years, every 6 months for 2 years, then annually, as long as there is no evidence of the disease.

All patients with bladder cancer who had outpatient appointments for cystoscopic examinations or chemotherapy and met the inclusion criteria, were approached to

participate in the study. The criteria for inclusion in the study were:

1. Male
2. Pathological confirmation of diagnosis of bladder cancer
3. Knowledge of diagnosis
4. Ability to read and understand English
5. Age 55 or older
6. Consent to participate

Two of those approached did not know they had "cancer" and two were unable to read and explain the paragraph on cystoscopic examination that was used to screen reading ability. These four were excluded from participation in the study.

#### Data Collection Methods

The problems encountered by patients with bladder cancer were assessed with a self-administered questionnaire. The methods patients use for coping were measured by a coping checklist. Effectiveness of coping was measured by subjects' response to a single item.

The Cancer Rehabilitation Evaluation System (CARES) (Schag & Heinrich, 1988b) Questionnaire assesses the type and severity of problems cancer patients encounter as they live with the disease and its treatment. The short-form

(CARES-SF), used in this study, contains 59 items. (A copy is included in Appendix A.)

The items are grouped into five subscales and one scale of miscellaneous items. The physical subscale measures the physical changes and disruption of daily activity caused by the disease. It contains 10 items, such as "I do not have the energy I used to" and "I have difficulty bending." The psychosocial subscale assesses psychological issues, communication and relationship (other than with partners) problems. This subscale contains 17 items, such as "I am uncomfortable with the changes in my body" and "I frequently feel anxious." The sexual subscale contains problems related to interest and performance of sexual activity. It consists of 3 items, such as "I do not feel sexually attractive." The marital subscale assesses problems associated with a significant marital-type relationship. It contains 6 items, such as "My partner and I have difficulty talking about wills and financial arrangements" and "My partner and I are not getting along as well as we usually do." The medical interaction subscale assesses problems interacting and communicating with the medical team. It is measured with 4 items, such as "I have difficulty understanding what the doctors tell me about the cancer or its treatments." Nineteen miscellaneous items include "I have financial problems" and

"I have times when I do not have control of my bladder."

Respondents are asked to indicate how much each statement applied to them in the last month. Responses are rated on a 5-point scale from 0 (not at all) to 4 (very much). The total number of endorsed problems represents the number of problems endorsed with a rating of 1 or greater. A total severity rating is calculated by summing all of the ratings for each item and is used only to create other scores. An average Severity score is obtained by dividing the total severity rating by the total number of problems the subject endorses. A Global score is calculated by dividing the total severity rating by the number of potential problems (including those rated 0). The Global score is the best overall index of the patient's status (Schag, Heinrich, Aadland, & Ganz, 1990). Severity and Global scores are calculated for each of the five subscales. The scores vary according to the number of problems an individual experiences and the severity of those problems. High scores indicate an individual is experiencing a large number of distressing problems. Low scores indicate an individual is experiencing few distressing problems.

The longer form of the CARES, also known as the Cancer Inventory of Problem Situations (CIPS), contains 139 items. It was developed from searches of literature, interviews



with patients and families, and discussions with health care professionals caring for cancer patients (Schag et al., 1990). The CARES-SF was developed primarily for use in research. All items contained on the short form are included in the original CARES. Items on the CARES-SF were initially selected on the basis of inter-item correlations and alpha coefficients on data from the long form.

Professionals who work with cancer patients and were familiar with using the long form selected items they perceived as most important in evaluating patients and planning interventions. Final selection of items on the CARES-SF was based on their judgement of the clinical significance of items in combination with item's frequency of use in a heterogeneous sample of 479 patients (Schag & Heinrich, 1988a).

Four existing measures were used to evaluate CARES (Schag & Heinrich, 1988a). The data were re-analyzed for the CARES-SF. The Global Severity Index of the Symptom Checklist-90 (a measure of psychological distress) strongly correlated with the total CARES-SF ( $r = .74, p < .0001$ ) and the psychosocial subscale ( $r = .70, p < .0001$ ). The Karnofsky Performance Status score (a measure of physical functioning) correlated with the physical subscale ( $r = -.68, p < .0001$ ), showing that as functional status declines, physical problems increase. The Dyadic Adjustment Scale (a

measure of marital functioning) correlated with the marital subscale ( $r = -.56, p < .0001$ ), showing that as marital relationships become more dysfunctional problems increase. A Visual Analogue Scale was used to measure patients' quality of life before cancer (QOL-B) and quality of life since developing cancer (QOL-A). While QOL-A had significant correlations with the total CARES-SF and each subscale, it had the highest correlations with the total CARES-SF ( $r = -.55, p < .0001$ ), the physical subscale ( $r = -.52, p < .0001$ ), and the psychosocial subscale ( $r = -.53, p < .0001$ ). These correlations indicate that a more positive response on the quality of life scale is associated with lower scores on the CARES-SF. There was no relation between quality of life before cancer and the CARES-SF.

Test-retest reliability, conducted at an average 10 day interval with 120 patients, is reported to be .86 for the total CARES-SF with the subscales ranging from .81 to .86. Reported alpha coefficients for the five subscales range from .67 to .85 (Schag & Heinrich, 1988a).

The Ways of Coping checklist (revised) is a 50 item inventory of coping strategies (Folkman et al., 1986). (A copy is included in Appendix B.) The items are grouped into eight forms of coping. Confrontive strategies are aggressive efforts to alter the situation. They are tapped by 6 items, such as "stood my ground and fought for what I

wanted" and "I let my feelings out somehow." Distancing strategies are efforts to detach oneself from the situation. They are measured by 6 items, such as "made light of the situation; refused to get too serious about it" and "went on as if nothing happened." Self-controlling strategies are efforts to regulate one's feelings. They are assessed by 7 items, such as "I tried to keep my feelings to myself" and "kept others from knowing how bad things were." Seeking social support strategies are efforts to seek informational support. They are tapped by 6 items, such as "talked to someone about how I was feeling" and "accepted sympathy and understanding from someone." Accepting responsibility strategies acknowledge one's role in the problem. They are evaluated by 4 items, such as "criticized or lectured myself." Escape-avoidance strategies describe wishful thinking. They are assessed by 8 items, such as "hoped a miracle would happen" and "tried to make myself feel better by eating, drinking, smoking, using drugs or medications, etc." Planful problem-solving strategies are deliberate problem-focused efforts to alter the situation. They are measured by 6 items, such as "I knew what had to be done, so I doubled my efforts to make things work" and "just concentrated on what I had to do next--the next step." Positive reappraisal strategies are efforts to create positive meaning by focusing on personal

growth. They are evaluated by 7 items, such as "changed or grew as a person in a good way" and "rediscovered what is important in life."

Respondents were asked to indicate how frequently they used each strategy to cope with their illness during the past month. Responses range from 0 (not used) to 3 (used a great deal). The score for each subscale is the sum of the scores of the items within it.

The Ways of Coping checklist originally contained 68 items developed from a review of the literature on coping responses and constructed from Lazarus's theoretical framework (Folkman et al., 1986). The items on the Ways of Coping checklist are similar to items on other measures of coping (Jaloweic, Murphy, & Powers, 1984; Moos et al., 1984; Weisman, 1979).

The revised Ways of Coping with its coping subscales was derived by factor analysis of the results of a study on coping in a sample of community residing adults. Reported alpha coefficients for the eight subscales range from .61 to .79 (Folkman et al., 1986).

To measure perceived efficacy of coping, subjects were asked to respond to the question "How well do you feel you have coped with cancer of the bladder during the past month?" Subjects rated their response on a 5-point scale from 0 (not at all well) to 4 (very well). (A copy is

included in Appendix C.)

A patient information form was included to collect data on the subjects' age, level of education, marital status, employment status, proximity of other family, perceived support of family and friends, and income, as these are factors that might affect how individuals cope. (A copy is included in Appendix D.) An additional form was used to collect information from the subjects' medical record. This information included length of illness, number of recurrences, type of treatment, and presence of other medical conditions. (A copy is included in Appendix E.)

#### Design and Procedure

The design of this study is descriptive and correlational. Outpatients were approached as they arrived for their appointment. The purpose of the study was explained. (A copy of the information and consent form is included in Appendix F.) After the patients gave consent to participate in the study, they were screened for reading ability. Subjects were taken to a private room to complete the questionnaires in the presence of the investigator. They first completed the patient information form, then the CARES-SF, followed by the Ways of Coping, and finally the statement on the efficacy of coping. These instruments

were reproduced using large print to enhance ease in reading. The investigator completed the medical information form using the subjects' medical record at that time. The study was conducted from May to September of 1989.

#### Data Analysis

Descriptive statistics, including measures of central tendency and ranking were the major forms of data analysis. Pearson correlations were computed for the 5 summary scales of the CARES-SF and the 8 scales on the Ways of Coping checklist. It should be noted that using such a correlation does not accurately reflect the interaction of more than one type of coping with the type of problem. The small sample size precluded the use of other means to analyze relationships. Alpha reliabilities were calculated for each of the scales.

## CHAPTER III

### RESULTS AND DISCUSSION

This section will discuss the results of the study. First the sample is described and compared with a sample of men with prostate cancer and the local population. The research questions are answered in the next section. For the purpose of clarity, the results and discussion are presented in each section.

#### Description of Sample

The sample consisted of 20 men with ages ranging from 56.8 to 78.8 years ( $M = 66.9$ ,  $SD = 6.8$ ). The sample is fairly representative of the Roseburg VAMC population of patients with bladder cancer, whose ages range from 39 to 90 ( $M = 69.7$ ,  $SD = 9.1$ ).

Most of the men were Caucasian (95%) and Protestant (80%). The majority were married (65%), and 12 (63%) had at least graduated from high school. Most (80%) had annual incomes of less than \$15,000, and almost all (90%) of the men were not working. The two who were working were only

working part time (see Table 1).

Of the 18 subjects responding to the question, 72% reported having at least one relative living within 50 miles. On a 5-point Likert scale from 0 (not at all) to 4 (very much), subjects rated their family ( $M = 3.5$ ,  $SD = 1.0$ ) and friends ( $M = 3.6$ ,  $SD = .65$ ) as giving them much support in their treatment program. A more detailed assessment of social support was beyond the scope of this study. Perceived availability of social support was found to have a positive relationship with coping effectiveness in McNett's (1987) study of functionally disabled adults.

The majority of the subjects (75%) had one or more other medical conditions. These conditions were arteriosclerotic vascular disease ( $n = 8$ ), hypertension ( $n = 6$ ), chronic obstructive pulmonary disease ( $n = 5$ ), arthritis ( $n = 2$ ), and diabetes ( $n = 2$ ). These findings are consistent with those of other researchers (Ganz, Schag, & Heinrich, 1985), who have found a high incidence of other chronic illnesses among elderly cancer patients.

Six men were currently undergoing intravesicular chemotherapy. The other 14 men were having a cystoscopic examination for follow-up of their disease. Two of the men had been diagnosed with bladder cancer for 1 month or less. The time since diagnosis for the remaining 18 subjects ranged from 12 to 210 months ( $M = 71.2$ ,  $SD = 63.96$ ). Six



Table 1

Characteristics of Sample

Characteristic	n <sup>a</sup>	Percent
<u>Marital Status</u>		
Married	13	65
Widowed	3	15
Divorced	3	15
Separated	1	5
<u>Level of Education</u>		
Junior High (7-9)	6	32
Some high School (10-12)	1	5
High School Graduate	7	37
Some College or Trade School	5	26
<u>Employment Status</u>		
Part Time	2	10
Disabled	3	15
Retired	12	60
Unemployed	3	15
<u>Annual Income</u>		
\$5,000-14,999	18	90
\$15,000-25,000	2	10

<sup>a</sup>Some subjects did not respond to all items.

men had never had a recurrence, and nine had had 2 or more recurrences.

The two who were newly diagnosed fit Weisman's phase of existential plight. The remaining 18 could be placed in Weisman's phase of accommodation and mitigation. This is the phase during which individuals incorporate the disease into their daily life. It is probable that even those who had had a recurrence had accommodated themselves to their disease in the length of time available to do so. As Heinrich and Schag (1988) suggested, patients living with cancer adjust to their illness with time.

Data from this study were compared with data from a normative sample of men with prostate cancer obtained during the development of the CARES instrument (Schag & Heinrich, 1988a). It was felt that since both cancers affect the genitourinary system, and both samples were composed only of men and included veterans, a comparison could reasonably be made.

While the ages of the two groups were similar, there were differences between the two groups on several demographic variables. The prostate cancer group was better educated (54% had at least attended college compared with 26% of the bladder cancer group). Although most (70%) of the prostate cancer group were not working, more of them were working than those with bladder cancer. A

slightly higher percentage of the group with prostate cancer were married (74%).

The 20 men in this sample are from a veteran population living in nine predominately rural counties in southwestern Oregon and northern California. Population statistics for those Oregon counties for the year 1980 reveal that 70 per cent of the men have a high school education, 56 percent of men age 55 to 64 are employed, and 12 percent of men age 65 and older are employed. Median incomes, in 1980, for men age 55 to 64 ranged from \$19,000 to \$22,000 and for men age 65 and older range from \$10,000 to \$12,500. The sample in this study had a lower employment rate (10%), and a slightly lower percentage of high school graduates (63%).

#### Research Questions

1) What problems are most frequently experienced by men with bladder cancer?

The short form of the Cancer Rehabilitation Evaluation System (CARES-SF) was used to identify the problems these veterans encountered and the impact these problems had on their lives. Of the 59 items on the instrument, the minimum number of items to which a subject could respond was 38, and the maximum number was 52. There were 4 items that did not apply to any of the subjects in the present

study.

Responses were scored to determine the number of problems, the average severity of these problems, and the overall impact of cancer on their lives. The number of problems was obtained by counting the number of items that each subject endorsed (rated at 1 or greater). The severity score was determined by dividing the total severity rating by the number of items endorsed. The overall impact was determined by calculating a global score, dividing the total severity rating by the number of potential problems (including those rated 0).

Global scores were also computed for each of the five summary scales; physical, psychosocial, marital, sexual, and medical interaction. Those items not included in the 5 summary scales made up a miscellaneous scale, for which no separate global score calculations were made.

Internal consistency for the 5 summary scales was evaluated. The alpha coefficients for the current study were higher than those of a normative sample (Schag & Heinrich, 1988a) (see Table 2). The only alpha coefficient below .80 for the bladder cancer group was for the sexual scale. The length, only 3 items, could account for the lower alpha (.70) for this scale. The alpha coefficients of the CARES-SF were determined to be satisfactory for the purposes of this study.

**Table 2**

Alpha Coefficients for CARES-SF: Bladder Cancer and Normative Samples.

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CARES-SF Summary Scales	Bladder Cancer (N = 20)	Normative Sample (N = 1047)
Physical	.89	.85
Psychosocial	.86	.85
Marital	.81	.72
Sexual	.70	.67
Medical Interaction	.90	.67

---

Out of 55 possible problems, these veterans with bladder cancer endorsed an average of 21.7 problems that applied to them (range 8 - 37, SD = 9.4). They rated these problems as being moderately severe (M = 1.95, SD = .95). When compared with the sample of men with prostate cancer (Schag & Heinrich, 1988a), these men with bladder cancer had higher scores indicating greater distress. The differences between 6 of these scores were statistically significant as determined by means of t-Test (see Table 3).

The items on the CARES-SF were ranked according to the number of subjects endorsing them (see Table 4). The most frequently endorsed problems were physical, psychosocial, or sexual in nature. Two items from the miscellaneous scale were also among those most frequently endorsed. Decreased energy was a problem for 19 subjects, followed by worry about progression of the disease (n = 16). Of all the problems endorsed, decreased frequency of sexual intercourse was the one with the highest severity rating (M = 3, SD = .85). Lack of bladder control (n = 14) was high on the list of problems, as one might expect among men with cancer of the bladder. While financial problems (n = 13) were a frequent concern for these low income veterans, insurance problems (n = 5) were low on the list, since these men do not have to pay for their health care.

Problems from the marital and medical interaction

Table 3

Comparison of Bladder Cancer and Prostate Cancer Mean Scores on CARES-SF: Number, Severity, and Type of Problems

Measure	Patients With				
	<u>Bladder Cancer</u> (N = 20)		<u>Prostate Cancer</u> (N = 283)		t-Test
	Mean	SD	Mean	SD	
Number of Problems	21.70	9.40	12.78	7.59	4.89**
Average Severity	1.95	.95	1.75	.60	1.50
Total CARES-SF Score	1.09	.82	.54	.43	5.09**
Summary Scales Scores					
Physical	1.21	.90	.66	.66	2.93*
Psychosocial	1.18	.99	.54	.52	4.46**
Marital	.78 <sup>a</sup>	1.14	.30 <sup>b</sup>	.47	3.48**
Sexual	1.41	1.11	1.24	1.14	.65
Medical Interaction	.90	1.26	.37	.57	3.58**

Note. The Scores range from 0 (not at all) to 4 (very much).

<sup>a</sup>n = 16. <sup>b</sup>n = 231.

\*p < .01. \*\*p < .001

**Table 4**

Ranking of Problems by Frequency of Endorsement and Their Mean Severity Scores

Scale <sup>a</sup>	Problem	Rank	Mean <sup>b</sup>	SD
PHYS	Decreased energy	1	2.2	1.0
PSYCH	Worry about cancer progressing	2	2.1	1.3
PSYCH	Difficulty concentrating	3.5	2.1	.9
MISC	Lack of bladder control	3.5	2.1	1.8
PHYS	Cancer interferes with work	6.5	2.5	1.0
MISC	Financial problems	6.5	2.4	1.3
PSYCH	Uncomfortable with body changes	6.5	2.3	1.9
PSYCH	Feel anxious	6.5	2.2	1.6
SEX	Less frequent intercourse	11.5	3.0	.8
PSYCH	Difficulty sleeping	11.5	2.7	1.2
PHYS	Difficulty bending	11.5	2.4	1.4
PSYCH	Difficulty asking for help	11.5	2.1	1.7
SEX	Feel sexually unattractive	11.5	1.8	1.0
PHYS	Difficulty planning activities	11.5	1.7	1.0

<sup>a</sup>Summary scale that includes item. PHYS = Physical.

PSYCH = Psychosocial. MISC = Miscellaneous. SEX = Sexual.

<sup>b</sup>Mean severity score for those experiencing the problem.

Scores range from 0 (not at all) to 4 (very much).



subscales were not among the items most frequently endorsed. These results are consistent with the findings of others (Ganz et al., 1985; Schag & Heinrich, 1988), who have found that problems in the areas of relationships and medical interaction were less frequent and less severe than those in other areas.

In their study on adjustment following cancer surgery, Oberst and James (1985) used 11 broad categories to code the problems experienced by patients during the first 6 months following diagnosis. Problems endorsed frequently in the current study fit into 6 of these categories.

Disruption of life-style might include the following problems: "cancer or its treatments interfere with ability to work" (n = 13); "the frequency of sexual intercourse has decreased" (n = 12); and "difficulty planning activities because of cancer or its treatments" (n = 12).

Symptom distress was the area of most concern for the subjects in the Oberst and James study. Frequently cited problems by the bladder cancer patients in this area include: "decreased energy" (n = 19); "lack of bladder control" (n = 14); "difficulty concentrating" (n = 14); "difficulty bending" (n = 12); and "difficulty sleeping" (n = 12).

Uncertainty would seem to be inherent with the diagnosis of cancer. For the men with cancer of the

bladder, this concern was best found in their response to the statement "I worry about whether the cancer is progressing" (n = 16). Emotional distress is exemplified by the statement "I frequently feel anxious" (n = 13).

The incidence of problems with identity were low in the Oberst and James study. For the men in the current study, two of the frequently endorsed problems fit this category. They are: "uncomfortable with changes in the body" (n = 13) and "do not feel sexually attractive" (n = 12). "Financial problems" were experienced by 13 of the men with bladder cancer, yet were not frequently mentioned by the middle and upper income patients in the other study.

The similarities of responses in these two studies indicates the importance of finding the commonalties that are part of the cancer experience. It is interesting to note that many of the problems identified in the early months following diagnosis in the study by Oberst and James were also problems for the men in the current study, many of whom had lived with bladder cancer for several years. One wonders if the problems would persist had the patients received assistance early in the course of the disease.

The differences between the two studies may be due in part to the different socioeconomic status of the two groups. A major contribution to the differences is the methodology used to identify problems. Because problems in

the Oberst and James study were coded from an interview, the same problems were not addressed with each subject. In the current study, all subjects responded to the same list of problems. The advantage of the first method is being able to learn more about particular concerns of an individual. The advantage of the second method is being better able to compare the responses of the subjects.

Patient education and discharge planning are essential aspects of caring for patients. Knowing what problems a patient is experiencing helps focus teaching and planning efforts. The fact that 12 of the bladder cancer patients in the current study indicated they had difficulty asking for help suggests the importance of nurses being able to anticipate patients' concerns so that assistance can be given for managing problems.

2) What coping strategies are most frequently used by men with bladder cancer?

The revised Ways of Coping checklist was used to determine how these men cope with the stresses of bladder cancer. The 50 items on the checklist are divided into 8 scales representing different types of coping. The scales were scored by summing the rating on each scale.

Alpha coefficients for each scale were computed using the responses in this study and compared with a community

sample of middle-aged married couples (Folkman et al., 1986) (see Table 5). The alphas in the current study (range .62 to .82) are similar but slightly higher than those in the community sample (range .61 to .79). This indicates that the reliability of three of the Ways of Coping scales were slightly below the minimum level of .70 for research purposes.

A variety of types of strategies was used to cope with bladder cancer. Distancing ( $M = 1.2$ ,  $SD = .62$ ), self controlling ( $M = 1.07$ ,  $SD = .69$ ), positive reappraisal ( $M = 1.04$ ,  $SD = .69$ ), and planful problem solving ( $M = 1.01$ ,  $SD = .60$ ) were the most frequently used strategies (see Table 6).

It may be noted that escape-avoidance, accepting responsibility, and confrontive strategies were the least frequently used. While men in the current study did not confront the situation of their cancer, neither did they try to avoid it. The length of time that most of the men had lived with bladder cancer (a mean of 5.5 years for those not newly diagnosed) may be part of the reason that these strategies were less frequently used. The fact that accepting responsibility strategies were not used indicates that these men did not blame themselves for their disease.

The various coping strategies were ranked according to the number of subjects using them. Looking for the silver

**Table 5**

Alpha Coefficients for Ways of Coping: Bladder Cancer  
Patients and Community Sample

Ways of Coping Scale	Bladder Cancer Patients (N = 20)	Community Sample (N = 150)
Distancing	.66	.61
Self Controlling	.82	.70
Positive Reappraisal	.82	.79
Planful Problem Solving	.62	.68
Seeking Social Support	.66	.76
Escape-Avoidance	.75	.72
Accepting Responsibility	.70	.66
Confrontive	.79	.70

**Table 6**

Mean Scores on Ways of Coping Checklist for Bladder Cancer Patients (N = 20)

Type of Strategy	Mean	SD
Distancing	1.20	.62
Self controlling	1.07	.67
Positive Reappraisal	1.04	.69
Planful Problem Solving	1.01	.60
Seeking Social Support	.77	.70
Escape-Avoidance	.72	.56
Accepting Responsibility	.68	.60
Confrontive	.62	.60

Note. Scores range from 0 (not used) to 3 (used a great deal).

lining was the strategy used by more of the subjects ( $n = 16$ ) followed by talking to someone about feelings ( $n = 15$ ) and making light of the situation ( $n = 15$ ). The strategies used most often by those employing them were looking for the silver lining ( $M = 2.2$ ,  $SD = .78$ ), keeping feelings to self ( $M = 2.1$ ,  $SD = .83$ ), keeping feelings from interfering ( $M = 2.0$ ,  $SD = .88$ ), and praying ( $M = 2.0$ ,  $SD = .92$ ). As might be expected, these items are in the categories of types of coping most often used by the subjects (see table 7).

This study supports the work of other researchers (Baldree et al., 1982; Jaloweic & Powers, 1980; King, 1985; Miller, 1983) that suggests people use a mixture of strategies to cope with the stresses of illness. The use of different instruments to measure coping makes it difficult to compare the results of these studies. The different ways that Lazarus and his colleagues (Folkman et al., 1986) and Weisman and Worden (1976-77) conceptualize confrontive strategies illustrate this point. The Lazarus group describe confrontive strategies (the type least used in the current study) as aggressive efforts to alter the situation. Weisman and Worden classify confrontive coping strategies (a type associated with decreased vulnerability in their study) as those that take firm action based on current information. The Lazarus definition of planful

Table 7

Ranking of Coping Strategies by Frequency of Use and Their Mean Score

Type <sup>a</sup>	Strategy	Rank	Mean <sup>b</sup>	SD
DIST	Looked for silver lining	1	2.2	.8
SKSSP	Talked about feelings	2.5	1.3	.7
DIST	Made light of the situation	2.5	1.3	1.0
SELCO	Kept feelings to self	6	2.1	.8
SELCO	Kept feelings from interfering	6	2.0	.9
POSRE	Prayed	6	2.0	.9
PLPS	Knew what had to be done	6	1.9	.7
POSRE	Rediscovered what is important	6	1.8	.8
PLPS	Concentrated on the next step	11	1.9	.9
DIST	Went on as if nothing happened	11	1.8	.7
POSRE	Changed in a good way	11	1.5	.8
DIST	Refused to think much about it	11	1.5	.8
POSRE	Came out of experience better	11	1.5	1.0

<sup>a</sup>Type of coping. DIST = Distancing. PLPS = Planful

Problem Solving. POSRE = Positive Reappraisal.

SELCO = Self Controlling. SKSSP = Seeking Social Support.

<sup>b</sup>Mean score for those using the strategy. Scores range from 0 (not used) to 3 (used a great deal).



problem-solving coping strategies (a more frequently used strategy in the current study), as problem-focused efforts to alter the situation, more closely fits the Weisman and Worden definition of confrontation. Until more research has been done to operationalize the concept of coping, comparisons between studies will not be possible.

3) What is the relationship between the type of problem encountered and the choice of coping strategy?

Pearson correlation coefficients were computed between each of the 5 summary scales from the CARES-SF and the 8 types of coping on the Ways of Coping checklist (see Table 8). Seven types of coping had high correlations with psychosocial problems. Physical problems had significant correlations with seeking social support ( $r = .56, p < .05$ ) and distancing ( $r = .47, p < .05$ ) strategies. Marital problems had strongest relationships with the use of self controlling ( $r = .63, p < .01$ ) and distancing ( $r = .50, p < .05$ ) strategies. For sexual problems, self controlling ( $r = .57, p < .05$ ) and positive reappraisal ( $r = .53, p < .05$ ) strategies had the strongest relationships. None of the coping strategies had significant relationships with medical interaction problems.

Further support for the relationship between psychosocial problems and distancing, self controlling,

Table 8

Pearson Correlations Showing the Relationship of Coping Strategy to Problem

Type of Coping <sup>a</sup>	Type of Problem <sup>b</sup>				
	PHYS	PSYCH	MEDIN	MARI	SEX
DIST	.47*	.68**	.04	.50*	.40
SELCO	.45	.70***	.16	.63**	.57*
POSRE	.37	.45	.04	.30	.53*
PLPS	.16	.51*	-.24	-.04	-.05
SKSSP	.56*	.69**	-.13	.05	.12
ESAV	.33	.70**	.28	.19	.15
ACRES	.19	.59**	.23	.24	.25
CONFR	.35	.72***	.21	.21	.13

<sup>a</sup>DIST = Distancing. SELCO = Self Controlling. POSRE = Positive Rappraisal. PLPS = Planful Problem Solving. SKSSP = Seeking Social Support. ESAV = Escape/Avoidance. ACRES = Accepting Responsibility. CONFR = Confrontive.

<sup>b</sup>PHYS = Physical. PSYCH = Psychosocial. MEDIN = Medical Interaction. MARI = Marital. SEX = Sexual.

\* $p < .05$     \*\* $p < .01$     \*\*\* $p < .001$

accepting responsibility, and confrontive coping strategies was found using Chi-square analysis. The subjects were divided into groups according to those scoring high and low on each of the summary scales and each of the types of coping. Only these four relationships were significant.

A clearer understanding of the relationships between the CARES-SF and the Ways of Coping checklist can be obtained by examining some of the items within each scale. Frequently endorsed items from the CARES-SF summary scales are compared with the frequently used items from the Ways of Coping subscales. Such a comparison is theoretical in nature and is included only for illustrative purposes.

The physical scale on the CARES-SF contains such items as "decreased energy," "cancer interferes with work," "difficulty bending," and "difficulty planning activities." Distancing strategies, such as "going on as if nothing happened," help keep these concerns away. "Accepting sympathy and understanding" is a strategy of seeking social support that might help cope with these physical problems.

The psychosocial scale includes such items as "worry about cancer progressing," "difficulty concentrating," "uncomfortable with changes in body," "feeling anxious," "difficulty sleeping," and "difficulty asking family and friends for help." Such strategies as "looking for the silver lining" (distancing), "keeping others from knowing

how bad things are" (self controlling), "concentrating on the next step" (planful problem solving), "talking to someone about feelings" (seeking social support), "wishing the situation would go away" (escape-avoidance), "criticizing or lecturing oneself" (accepting responsibility), and "standing one's ground and fighting for what one wants" (confrontive) can help individuals manage these psychosocial problems.

Marital problems had the lowest rate of endorsement by the men in this study. The scale includes such items as "difficulty talking with partner about wills and finances," "not feeling like embracing, kissing, caressing," and "not getting along with partner as well as usual." Self controlling strategies, such as "keeping feelings from interfering," and distancing strategies, such as "refusing to think too much about it" may help with marital problems.

Sexual problems, such as "decreased frequency of sexual intercourse" and "feeling sexually unattractive," were a frequent concern for men in this study. Such strategies as "keeping feelings to self" (self controlling) and "rediscovering what is important" (positive reappraisal), may help these men cope with sexual problems.

The Ways of Coping checklist was designed mainly to measure coping with psychosocial problems, which may explain the strong relationship between this scale on the

CARES-SF and many of the coping scales. It is especially important that strategies used to cope with the physical effects of illness be included on an instrument designed to measure coping with the situation of illness.

The methodology of the current study made it impossible to relate specific problems to specific coping strategies. Using data obtained in interviews, Gotay (1964) was able to determine that some of the strategies used to cope with one problem, fear of cancer, were different from those generally used. As more research is done, a clearer understanding of the relationship between specific problems and choice of coping strategies should emerge. It is hoped that a method of studying coping can be found which lends itself for use in a clinical setting.

4) What is the relationship between perceived efficacy of coping and the choice of coping strategies?

In response to the statement on efficacy of coping, all but one subject rated themselves as coping "fairly well" or "very well." The one subject who responded that he was coping "somewhat well" had metastatic disease at the time of diagnosis and had undergone treatment continuously for the 4 years since diagnosis. Since there was little variation in the perceived efficacy of coping, it was not possible to look for a relationship with choice of coping

strategies. The lack of variance in this variable may be due to having only one item to measure it. Using only one item may cancel out the effect of individual coping strategies. It is also possible that the subjects may have selected the more desirable response in order to "look good." In all probability, it seems advisable to obtain efficacy ratings on each of the coping items.

Determining whether or not the outcome of coping is successful is essential to the study of the process of coping. Singer (1984) suggested that one difficulty in such a measurement is that evaluation of the outcome of coping is subject to the values of the individual making the observation. For example, health care professionals might view withdrawal from treatment as maladaptive, while the patient views it as adaptive.

The results of this study highlight the variety of types of problems experienced by men with bladder cancer, and the variety of methods they use to cope. While there is evidence of some relationship between type of problem and type of coping, the relationship between specific problems and specific strategies could not be determined by this study. The men in this study felt that they were coping well with their disease. The homogeneity of the sample make it possible to draw some conclusions about these veterans with bladder cancer, but the small sample

severely limits the generalization of findings.

## CHAPTER IV

### SUMMARY, CONCLUSIONS, RECOMMENDATIONS

In this section the study is briefly summarized. The conclusions are discussed, and recommendations are made for further research.

#### Summary

A descriptive correlational design was used to identify the problems encountered by men with bladder cancer and how they are managed. Attempts were made to examine the relationships between type of problem and type of coping strategy, and between efficacy of coping and choice of coping strategy.

A convenience sample of 20 men, over age 55 ( $M. = 66.9$ ,  $SD = 6.8$ ), being treated for bladder cancer at a rural Veterans Affairs Medical Center were asked to complete two self-report questionnaires, a demographic information form, and respond to a statement on perceived efficacy of coping. The CARES-SF was used to identify the problems encountered. The Ways of Coping checklist was used to measure the methods individuals use to cope.



Medical information was retrieved from the patients' records by the investigator.

The subjects endorsed an average of 21.7 problems and rated them as being moderately severe. The most frequently endorsed problems were physical, psychosocial, and sexual in nature. Six of the eight scores on the CARES-SF were significantly higher than those of a sample of men with prostate cancer.

A mixture of coping strategies were used. Items from the distancing, self controlling, positive reappraisal, and planful problem solving subscales on the Ways of Coping checklist were the ones most frequently chosen.

Psychosocial problems had the greatest number of significant relationships with the types of coping. There were significant relationships between some of the types of coping and all other problems, except medical interaction.

The great majority of subjects felt that they were coping effectively. Due to this lack of variance, no relationships with choice of coping strategies were examined.

The conclusions of this study are limited to men with cancer of the bladder. Since the sample all received their health care at a Veterans Affairs Medical Center, the findings are also limited to this population.

Bladder cancer can have some impact on all aspects of

a man's life. By identifying which problems are a specific concern of their patients and what ways are being used to manage them, nurses can better plan and use the resources that aid adjustment to living with bladder cancer.

### Conclusions

An instrument such as CARES appears to have some use for nurses to assess the problems their patients are experiencing in their efforts to adjust to living with bladder cancer. Once the problems have been identified, then appropriate interventions can be initiated.

Of special interest among the findings in this study was the significantly higher scores on the CARES-SF of the bladder cancer subjects, as compared to a normative sample of men with prostate cancer. A factor contributing to these differences may be that rural areas have fewer of the community resources available to those in urban areas represented by the normative sample. Veterans may not be taking advantage of those community services that do exist because of the lack of communication over the distances involved. If this is the case, more effort needs to be made to develop and use these community resources. Another factor that may have contributed to the differences is the higher educational level of the normative sample.

Since a variety of coping strategies are used to

manage the stresses of bladder cancer, it is important for nurses to know which ones their patients are currently using. With this knowledge, nurses can provide better support and guidance for the use of effective strategies. However, it appears that more research needs to be done to develop measures of coping which relate to dealing with physical problems of illness.

The majority of the sample felt that they were coping effectively with their problems, despite the number and severity of those problems. This demonstrates the strength of the human spirit's ability to survive. By increasing their understanding of those who do cope well, nurses can enhance their ability to help those who are not coping well.

#### Recommendations for Further Research

Despite the growing body of research on coping, more needs to be done to support the theory and measurement and thus increase understanding. There need to be more studies to explore the relationship of person factors, such as personality; environmental factors, such as poverty and social support; and situation factors, such as severity and type of disease; to the process of coping. The use of an instrument that measures functional ability, such as the Karnofsky Performance Status (Schag, Heinrich, & Ganz,

1984), would enhance the study of coping with illness.

The concept of primary appraisal is a difficult one to measure in a clinical research setting. Efforts need to be made to increase the knowledge of this aspect of the coping process. Development of an instrument that accurately measures the strategies used in coping with illness is badly needed. An inductive approach may be what is necessary to enhance the efforts to develop such an instrument. Determining whether or not the outcome of coping is successful is an inherent part of the process. Measurement of coping effectiveness should be a research focus. Nurses need to know when coping is not effective, so they can focus the majority of their efforts toward helping those who need it most.

Lazarus and Folkman (1984) define coping as "constantly changing." A longitudinal study is the only way to capture this change. Such a study of coping with cancer could support Weisman's model of the psychosocial phases of cancer. More needs to be known about both the impact of cancer and the coping strategies used at different time periods. Studies of coping with cancer need to focus on specific types of cancer, so that the effect of different prognoses and treatments on the coping process can be better delineated.

There are large numbers of veterans living in rural

areas of this country. More research needs to be done to determine if there are actual differences in the cancer experience between veterans in rural and urban areas.

Men with bladder cancer encounter a broad range of problems and use a wide variety of strategies to cope with them. By identifying what problems exist for patients and how these problems are managed, nurses can better develop and use the resources necessary to assist patients to cope with bladder cancer.

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APPENDIX A

**CARES-SF**  
**Cancer Rehabilitation Evaluation System**  
**Short Form**  
**For Research**

Patient ID#: \_\_\_\_\_

Date: \_\_\_\_\_

Instructions

Below is a list of Problem Statements that describe situations and experiences of individuals who have or have had cancer. Read each statement and circle the number that best describes **HOW MUCH EACH STATEMENT APPLIES TO YOU** during the **PAST MONTH, INCLUDING TODAY**. Some sections will not apply to you. Please skip these sections and proceed to the next one as directed.

Example

How much does it apply to you?

Not at all  
 A little  
 A fair amount  
 Much  
 Very much

- |                                      |   |   |   |   |   |
|--------------------------------------|---|---|---|---|---|
| 1. I have difficulty walking .....   | 0 | ① | 2 | 3 | 4 |
| 2. I find that food tastes bad ..... | 0 | 1 | 2 | 3 | ④ |

## CARES-SF

How much does it apply to you?	Not at all	A little	A fair amount	Much	Very much
1. I have difficulty bending or lifting .....	0	1	2	3	4
2. I do not have the energy I used to .....	0	1	2	3	4
3. I have difficulty doing household chores .....	0	1	2	3	4
4. I have difficulty bathing, brushing my teeth, or grooming myself .....	0	1	2	3	4
5. I have difficulty planning activities because of the cancer or its treatments .....	0	1	2	3	4
6. I cannot gain weight .....	0	1	2	3	4
7. I find food unappealing .....	0	1	2	3	4
8. I find that cancer or its treatments interfere with my ability to work .....	0	1	2	3	4
9. I frequently have pain .....	0	1	2	3	4
10. I find that my clothes do not fit .....	0	1	2	3	4
11. I find that doctors don't explain what they are doing to me .....	0	1	2	3	4
12. I have difficulty asking doctors questions .....	0	1	2	3	4
13. I have difficulty understanding what the doctors tell me about the cancer or its treatments .....	0	1	2	3	4
14. I would like to have more control over what the doctors do to me .....	0	1	2	3	4
15. I am uncomfortable with the changes in my body .....	0	1	2	3	4
16. I frequently feel anxious .....	0	1	2	3	4
17. I have difficulty sleeping .....	0	1	2	3	4
18. I have difficulty concentrating .....	0	1	2	3	4
19. I have difficulty asking friends or relatives to do things for me .....	0	1	2	3	4
20. I have difficulty telling my friends or relatives about the cancer .....	0	1	2	3	4

How much does it apply to you?	Not at all A little A fair amount Much Very much
21. I find that my friends or relatives tell me I'm looking well when I'm not.....	0 1 2 3 4
22. I find that my friends or relatives do not visit often enough .....	0 1 2 3 4
23. I find that friends or relatives have difficulty talking with me about my illness .....	0 1 2 3 4
24. I become nervous when I am waiting to see the doctor .....	0 1 2 3 4
25. I become nervous when I get my blood drawn .....	0 1 2 3 4
26. I worry about whether the cancer is progressing .....	0 1 2 3 4
27. I worry about not being able to care for myself .....	0 1 2 3 4
28. I do not feel sexually attractive .....	0 1 2 3 4
29. I am not interested in having sex .....	0 1 2 3 4
30. I sometimes don't follow my doctor's instructions .....	0 1 2 3 4
31. I have financial problems .....	0 1 2 3 4
32. I have insurance problems .....	0 1 2 3 4
33. I have difficulty with transportation to and from my medical appointments and/or other places .....	0 1 2 3 4
34. I am gaining too much weight .....	0 1 2 3 4
35. I have frequent episodes of diarrhea .....	0 1 2 3 4
36. I have times when I do not have control of my bladder .....	0 1 2 3 4
<b>Do you have children?</b>	<b>Yes No</b>
<i>If No, skip to next section.</i>	
37. I have difficulty helping my children cope with my illness.....	0 1 2 3 4

How much does it apply to you?		Not at all A little A fair amount Much Very much			
Are you working or have you been employed during the last month?		Yes	No		
<i>If No, skip to next section.</i>					
38.	I have difficulty talking to the people who work with me about the cancer .....	0	1	2	3 4
39.	I have difficulty asking for time off from work for medical treatments ...	0	1	2	3 4
40.	I am worried about being fired .....	0	1	2	3 4
Did you look for work during the past month?		Yes	No		
<i>If No, skip to next section.</i>					
41.	I have difficulty finding a new job since I have had cancer .....	0	1	2	3 4
Have you attempted sexual intercourse since your cancer diagnosis?		Yes	No		
<i>If No, skip to next section.</i>					
42.	I find that the frequency of sexual intercourse has decreased .....	0	1	2	3 4
Are you married or in a significant relationship?		Yes	No		
<i>If No, skip to next section.</i>					
43.	My partner and I have difficulty talking about our feelings .....	0	1	2	3 4
44.	My partner and I have difficulty talking about wills and financial arrangements .....	0	1	2	3 4
45.	I do not feel like embracing, kissing, or caressing my partner .....	0	1	2	3 4
46.	My partner and I are not getting along as well as we usually do .....	0	1	2	3 4
47.	My partner spends too much time taking care of me .....	0	1	2	3 4

How much does it apply to you?		Not at all A little A fair amount Much Very much				
48.	I have difficulty asking my partner to take care of me .....	0	1	2	3	4
Are you single and not in a significant relationship?		Yes	No			
<i>If No, skip to next section.</i>						
49.	I have difficulty initiating contact with potential dates .....	0	1	2	3	4
50.	I have difficulty telling a date about the cancer or its treatments .....	0	1	2	3	4
Have you had chemotherapy treatments in the last month?		Yes	No			
<i>If No, skip to next section.</i>						
51.	I become nervous when I get chemotherapy .....	0	1	2	3	4
52.	I become nauseated during and/or before chemotherapy .....	0	1	2	3	4
53.	I feel nauseated after I receive chemotherapy .....	0	1	2	3	4
54.	I vomit after chemotherapy .....	0	1	2	3	4
55.	I have other side effects after chemotherapy .....	0	1	2	3	4
Have you had radiation therapy treatments in the last month?		Yes	No			
<i>If No, skip to next section.</i>						
56.	I get nervous when I get radiation treatments .....	0	1	2	3	4
57.	I feel nauseous or vomit after my radiation treatments .....	0	1	2	3	4
Do you have an ostomy?		Yes	No			
<i>If No, skip to next section.</i>						
58.	I have problems with ostomy care and maintenance .....	0	1	2	3	4

How much does it apply to you?

Not at all  
A little  
A fair amount  
Much  
Very much

Do you have a prosthesis?

Yes No

*If No, skip to next section.*

59. I have difficulty with my prosthetic device (artificial limb, breast prosthesis, etc.) .....0 1 2 3 4



APPENDIX B

**WAYS OF COPING**

Patient ID*: _____  Date: _____			
<h3>Instructions</h3> <p>Below is a list of ways of coping with stress. Read each statement and circle the number that best describes HOW OFTEN YOU USED THIS WAY OF COPING WITH THE STRESSES OF BLADDER CANCER during the PAST MONTH, INCLUDING TODAY.</p>			
<h3>Example</h3>			
How often did you use this?		<i>Not used</i> <i>Used somewhat</i> <i>Used quite a bit</i> <i>Used a great deal</i>	
1. I went to visit a friend .....0	<input checked="" type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
2. I talked with my pastor .....0	<input type="radio"/> 1	<input type="radio"/> 2	<input checked="" type="radio"/> 3

How often did you use this?	Not used	Used somewhat	Used quite a bit	Used a great deal
1. Just concentrated on what I had to do				
next--the next step ..... 0	1	2	3	
2. I did something which I didn't think would				
work, but at least I was doing something ..... 0	1	2	3	
3. Tried to get the person responsible to				
change his or her mind ..... 0	1	2	3	
4. Talked to someone to find out more about				
the situation ..... 0	1	2	3	
5. Criticized or lectured myself ..... 0	1	2	3	
6. Tried not to burn my bridges, but leave				
things open somewhat ..... 0	1	2	3	
7. Hoped a miracle would happen ..... 0	1	2	3	
8. Went along with fate; sometimes I just				
have bad luck ..... 0	1	2	3	
9. Went on as if nothing happened ..... 0	1	2	3	
10. I tried to keep my feelings to myself..... 0	1	2	3	

How often did you use this?	<i>Not used</i>	<i>Used somewhat</i>	<i>Used quite a bit</i>	<i>Used a great deal</i>
11. Looked for the silver lining, so to speak;				
tried to look on the bright side of things .....0	1	2	3	
12. Slept more than usual .....	1	2	3	
13. I expressed anger to the person(s) who				
caused the problem .....	1	2	3	
14. Accepted sympathy and understanding from				
someone .....	1	2	3	
15. I was inspired to do something creative .....	1	2	3	
16. Tried to forget the whole thing .....	1	2	3	
17. I got professional help .....	1	2	3	
18. Changed or grew as a person in a good way .....	1	2	3	
19. I apologized or did something to make up .....	1	2	3	
20. I made a plan of action and followed it .....	1	2	3	
21. I let my feelings out somehow .....	1	2	3	
22. Realized I brought the problem on myself .....	1	2	3	
23. I came out of the experience better than				
when I went in .....	1	2	3	

How often did you use this?	Not used	Used somewhat	Used quite a bit	Used a great deal
24. Talked to someone who could do something concrete about the problem .....	0	1	2	3
25. Tried to make myself feel better by eating, drinking, smoking, using drugs or medication, etc. ....	0	1	2	3
26. Took a big chance or did something very risky .....	0	1	2	3
27. I tried not to act too hastily or follow my first hunch .....	0	1	2	3
28. Found new faith .....	0	1	2	3
29. Rediscovered what is important in life .....	0	1	2	3
30. Changed something so things would turn out all right .....	0	1	2	3
31. Avoided being with people in general .....	0	1	2	3
32. Didn't let it get to me; refused to think too much about it .....	0	1	2	3

How often did you use this?	Not used	Used somewhat	Used quite a bit	Used a great deal
33. I asked a relative or friend I respected for advice .....	0	1	2	3
34. Kept others from knowing how bad things were .....	0	1	2	3
35. Made light of the situation; refused to get too serious about it .....	0	1	2	3
36. Talked to someone about how I was feeling .....	0	1	2	3
37. Stood my ground and fought for what I wanted .....	0	1	2	3
38. Took it out on other people .....	0	1	2	3
39. Drew on my past experiences; I was in a similar situation before .....	0	1	2	3
40. I knew what had to be done; so I doubled my efforts to make things work .....	0	1	2	3
41. Refused to believe that it had happened .....	0	1	2	3
42. I made a promise to myself that things would be different next time .....	0	1	2	3

How often did you use this?	Not used	Used somewhat	Used quite a bit	Used a great deal
43. Came up with a couple of different solutions to the problem .....0	1	2	3	
44. I tried to keep feelings from interfering with other things too much .....0	1	2	3	
45. I changed something about myself .....0	1	2	3	
46. Wished that the situation would go away or somehow be over with .....0	1	2	3	
47. Had fantasies or wishes about how things might turn out .....0	1	2	3	
48. I prayed .....0	1	2	3	
49. I went over in my mind what I would say or do .....0	1	2	3	
50. I thought about how a person I admire would handle this situation and used that as a model .....0	1	2	3	

APPENDIX C

**Effectiveness of Coping**

Circle the number that matches the way you feel.	<i>Not at all</i> <i>Just barely</i> <i>Somewhat</i> <i>Fairly</i> <i>Very</i>
--	--

How well do you feel you have coped with cancer

of the bladder during the past month? .....0    1    2    3    4

## APPENDIX D

**Patient Information Form**

Please complete the following:

1. What is your age and date of birth? AGE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

2. What is the highest level of education you have completed? (Circle one)

1 2 3 4 5 6 7 8 9 10 11 12

COLLEGE: 13 14 15 16

POST GRADUATE: 17 HIGHEST DEGREE ATTAINED \* \_\_\_\_\_

\* If 10 - 12 are circled, note if High School graduate Yes \_\_\_ No \_\_\_  
If 13 - 17 are circled, note any type of degree awarded \_\_\_\_\_

3. What is your marital status? (Mark the appropriate choice)

\_\_\_ 1) Single / Never married

\_\_\_ 2) Married

\_\_\_ 3) Widowed

\_\_\_ 4) Divorced

\_\_\_ 5) Separated

\_\_\_ 6) Other (Please describe) \_\_\_\_\_



4. Living Arrangements: Number of adults in household \_\_\_\_\_

Number of children in household \_\_\_\_\_

5. Employment Status (Mark the appropriate choice)

- 1) Full time
- 2) Part time
- 3) Disabled How long? \_\_\_\_\_
- 4) Retired How long? \_\_\_\_\_
- 5) Unemployed

6. What is your current or prior occupation? \_\_\_\_\_

\_\_\_\_\_

7. How many of your close relatives live within fifty miles of you? \_\_\_\_\_

<p>Circle the appropriate choice.</p>	<p><i>Not at all</i></p> <p><i>A little</i></p> <p><i>A fair amount</i></p> <p><i>Much</i></p> <p><i>Very much</i></p>
---------------------------------------	--

8. Is your family supportive in your treatment program? .....0    1    2    3    4

Are your friends supportive in your treatment program? .....0    1    2    3    4

9. What is your religion? (Mark the appropriate choice)

- 1) Protestant
- 2) Catholic
- 3) Jewish
- 4) Other \_\_\_\_\_

10. What is your ethnic background (race)? (Mark the appropriate choice)

- 1) Asian
- 2) Black
- 3) Caucasian
- 4) Mexican-American
- 5) Native American
- 6) Other \_\_\_\_\_

11. What is the approximate income from all sources you anticipate this year (1989)? (Mark the appropriate choice)

- 1) \$ 0 - \$ 4,999
- 2) \$ 5,000 - \$ 14,999
- 3) \$ 15,000 - \$ 24,999
- 4) \$ 25,000 - \$ 34,999
- 5) \$ 35,000 - or more

APPENDIX E

**Medical Information**  
(Obtained from Subject's Medical Record)

1. Date of Diagnosis \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

2. Type of Tumor(s) \_\_\_\_\_  
\_\_\_\_\_

3. Number of Recurrences \_\_\_\_\_  
Dates Type

_____	_____
_____	_____
_____	_____

4. Chemotherapy Yes \_\_\_\_\_ No \_\_\_\_\_  
Dates Type

_____	_____
_____	_____
_____	_____
_____	_____



## APPENDIX F

**Roseburg Veterans Administration Medical  
Center  
Consent Form**

A. TITLE Coping with Bladder Cancer

PRINCIPLE INVESTIGATOR Virginia A. Brittsan, R.N.  
Master's Student  
Oregon Health Sciences University

B. PURPOSE

The purpose of this study is to identify the problems I have experienced with bladder cancer and how I managed these problems. The information gained from this research should make it possible for nurses to help those with bladder cancer cope better. My participation in the study will be limited to today.

C. PROCEDURES

I will be asked to complete two questionnaires and answer some brief questions about myself. My medical records will be used to obtain additional information.

D. RISKS AND DISCOMFORTS

Completing the questionnaires will take some of my time, but there are no risks involved.

E. BENEFITS

I may not personally benefit from participating in this study, but by serving as a subject, I may contribute new information which may benefit patients in the future.

F. ALTERNATIVE PROCEDURES

Procedures scheduled by Dr. Young will remain the same whether or not I participate in this study.

G. CONFIDENTIALITY

Information concerning me will be kept strictly confidential. A code number will be assigned to me, so that the investigator will not know who completed the questionnaire. Neither my name nor my identity will be used for publication or publicity purposes.

H. COSTS

It will cost me nothing to participate in this study.

Virginia Brittsan will answer any questions I might have. She may be reached at (503) 440-1000 Ext. 4610.

Participation in this study is voluntary. I may refuse to participate, or I may withdraw from this study at any time without affecting my relationship or treatment at the Roseburg Veterans Administration Medical Center.

The person signing this consent form will receive a copy of it. My signature below and on the Agreement to Participate in Research indicates that I have read the foregoing and agree to participate in this study.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

**ABSTRACT**

Title: Coping with Bladder Cancer

Author: Virginia A. Brittsan

Approved: \_\_\_\_\_

May E. Rawlinson, Ph.D., Advisor

A descriptive correlational design was used to identify the problems encountered by men with bladder cancer and how they are managed. Attempts were made to examine the relationships between type of problem and type of coping strategy, and between efficacy of coping and choice of coping strategy.

A convenience sample of 20 men, over age 55 ( $M = 66.9$ ,  $SD = 6.8$ ), being treated for bladder cancer at a rural Veterans Affairs Medical Center were asked to complete two self-report questionnaires, a demographic information form, and respond to a statement on perceived efficacy of coping. The CARES-SF was used to identify the problems encountered. The Ways of Coping checklist was used to measure the methods individuals use to cope. Medical information was retrieved from the patients'

records by the investigator.

The subjects endorsed an average of 21.7 problems and rated them as being moderately severe. The most frequently endorsed problems were physical, psychosocial, and sexual in nature. Six of the eight scores on the CARES-SF were significantly higher than those of a sample of men with prostate cancer.

A mixture of coping strategies were used. Items from the distancing, self controlling, positive reappraisal, and planful problem solving subscales on the Ways of Coping checklist were the ones most frequently chosen.

Psychosocial problems had the greatest number of significant relationships with the types of coping. There were significant relationships between some of the types of coping and all other problems, except medical interaction.

The great majority of subjects felt that they were coping effectively. Due to this lack of variance, no relationships with choice of coping strategies were examined.

The conclusions of this study are limited to men with cancer of the bladder. Since the sample all received their health care at a Veterans Affairs Medical Center, the findings are also limited to this population. Recommendations are made for further research.