

Anger expression, partner support, and quality of life in cancer patients

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Abstract

Objective: Family members are the most important source of social support for cancer patients. The determinants of family support, however, are not well understood. In this study, the associations of anger-expression styles of both patients and their partners with patient-perceived partner support and the impact of these variables on long-term health-related quality of life (HRQL) of the patient were examined. **Method:** The baseline data were collected at the time of diagnosis; a follow-up survey was conducted at 8 months. Questionnaires included the Spielberger AX scale, the Family Support scale, and the RAND-36 Health Survey. The sample comprised 153 patients and their partners. The theoretical model was tested with a path analysis using structural equation modeling, and gender differences were tested using multivariate analysis of covariance. **Results:** Path analyses indicated that partner support was an important mediator, partly explaining the associations between anger-expression styles and HRQL. As hypothesized,

anger control had a positive relationship with perceived partner support, while habitual inhibition of anger (anger-in) showed a negative correlation with partner support. Analyses by gender revealed some clear differences: for the male patients, the wife's high level of anger expression (anger-out) was significantly positively related to patient mental HRQL, whereas for the female patients, their husband's anger-out was negatively correlated with the patient's mental HRQL. In addition, patient's own anger-out had a more pronounced negative effect on HRQL for women as compared to men. **Conclusion:** The anger-expression styles of both patients and their partners seem to modify the family atmosphere, and together, they are important determinants of the long-term quality of life of the cancer patients. Interventions for couples facing cancer should include a focus on ways of dealing with anger and thereby support dyadic coping with cancer.

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Introduction

Patients with cancer who perceive high levels of social support have been reported to better cope with their illness [1–3]. Family members and especially partners are known to be the most important source of social support for patients facing a serious illness [4–6]. Coping with cancer involves many emotions affecting the perceived outcomes of the patients as well as those close to them. Along with feelings of

depression and anxiety, anger is a well-recognized emotion in the adjustment to the cancer diagnosis. Losses and other negative consequences of illness may lead to greater anger both in patients and in family members. From this perspective, it seems plausible that different ways of handling anger might be important factors modifying the atmosphere in a given family setting and affecting how a family member copes with illness. However, the impact of cancer patients' and their spouses' anger-expression styles on the patient perception of partner support and the later quality of life has not been previously studied.

Support given by the family or partner is known to predict better quality of life [1] and adjustment to the disease in cancer patients [7,8]. Nevertheless, relatively little is known

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about the relationship of the patient and partner's personal characteristics on patient-perceived partner support. Some specific psychosocial aspects of partner support, such as high empathy and low withdrawal, have been shown to be associated with good adjustment [3,9,10]. There are, however, also controversial results on how close relationships are involved in the adjustment to major life crises, such as cancer. If patients exhibit high levels of distress, they may risk alienating significant others. Vice versa, partners having difficulties with the demands of role and lifestyle changes may add to the patient's distress instead of buffering against it [4,5,11].

Previous research on social support has been based on the assumption that social support, as an independent causal factor, has a positive impact on physical and mental health. Recently, this narrow view of social support has been seriously questioned [5,8]. It seems reasonable to assume that there is an ongoing, dynamic interplay between the personality characteristics and the level of perceived support of the partners. Therefore, it seems that the shift towards the concept of social support as a dependent variable opens important avenues in investigating the dyadic coping with cancer.

Relatively little research has been reported on possible gender differences according to patient–partner status in psychological reactions to cancer. In an early study by Baider et al. [12], it was found that in 39 colon cancer couples, the adjustment of male patients was better than that of female patients, while in the group of partners, the opposite was true. While there are some contradictory results [13], in general, the literature suggests that partners report more distress than patients do [4,7], and female partners usually experience more distress than male partners [14]. In addition, our previous results have indicated substantial gender differences regarding partner support and health-related quality of life (HRQL). Social support seems to be more important for women [15]. Women have also been reported to possess more accurate understanding of their partner's experience with cancer and perceptions regarding social support in the relationship than men [16]. Moreover, significant gender differences in anger expression have been found in previous studies [17,18].

Earlier research has also suggested that habitual inhibition of anger (anger-in) has negative effects on available social support, whereas controlling one's anger (anger control) is more adaptive and is known to be positively related to social support [19–21]. Furthermore, high levels of anger expression (anger-out) among patients with a pulmonary illness have been associated with decreased social engagement among support providers [22]. On the other hand, greater anger-out has recently been associated with a higher quality of life and lower depression in patients with breast cancer [23,24]. Thus, given the previous results that social support has a positive impact on quality of life and anger expression seems to relate with social support, it seems reasonable to assume that social support serves as an important mediating

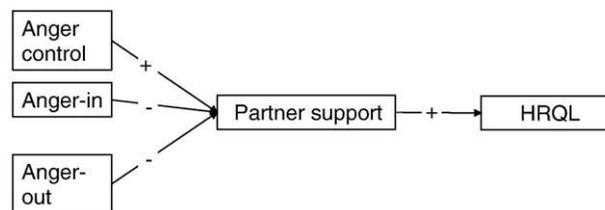


Fig. 1. Schematic theoretical model.

factor between anger expression and HRQL. Although high levels of anger have been associated with other psychological problems, research on anger and anger reduction in cancer patients has lagged behind research on other emotional problems [8,25]. In recent years, anger expression in psycho-oncological research has been, to a large extent, overlooked.

Aim of the study

The abovementioned reports raise several questions about the nature of the dyadic and marital relationship in different settings of patient–partner roles and its impact on the adjustment of cancer patients. The influence of anger on patient-perceived social support and quality of life has not been previously studied and clearly needs more clarification. Therefore, the present study examines the anger-expression styles of cancer patients and their partners and the impact of these factors on patient-perceived partner support as well as on long-term HRQL. The hypotheses (illustrated schematically in Fig. 1) were that

1. anger-in (i.e., anger suppression/inhibition) and anger-out (i.e., anger expression) in either of the partners would be inversely related to perceived partner support and patient's HRQL;
2. anger control, a constructive way of coping with anger, should be associated with high partner support and good HRQL; and
3. partner support would mediate the effects of anger expression on HRQL.

Moreover, we wanted to explore possible gender differences in the relationships among the study variables.

Methods

Procedure

This substudy is part of a larger research project aimed at investigating the psychosocial consequences of cancer and HRQL in patients as well as in their family members. The baseline data were collected about 2 months after the diagnosis (range, 0.5–6 months; median, 1 month); 88.2% of the participants answered within 3 months. The first follow-up survey was conducted about 8 months after the diagnoses (i.e., 6 months after the baseline measurements)

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