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GENERAL AND ILLNESS-SPECIFIC ADJUSTMENT TO CANCER: RELATIONSHIP TO MARITAL STATUS AND MARITAL QUALITY

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Abstract—This study examined the relationship between psychological adjustment of adults with cancer and two marital variables: married versus unmarried and high versus low marital quality. Eighty-six married and 46 unmarried adults with cancer completed general and illness-specific measures of psychological adjustment. In general, men and subjects with low marital quality reported more depression and anxiety, a less positive health care orientation, and more illness-induced family difficulties than did women and subjects with high marital quality; unmarried subjects reported more dysphoric thoughts and feelings related to the their illness than did married subjects; and unmarried men reported more disruption in work activities and extended family relationships than did unmarried females or married subjects. Moreover, a greater percentage of unmarried subjects and subjects with low marital quality reported clinically elevated levels of symptomatology compared to those with high marital quality. The clinical implications of these findings are discussed.

Keywords: Adults; Cancer; Marital status; Marital quality.

INTRODUCTION

The emotional challenges of a cancer diagnosis have been well documented. For instance, estimates of anxiety and depression among adults with cancer range from 5% to 58% [1–4] and underscore the emotional impact of the disease. However, in recent years, researchers increasingly have directed attention to studying the association between psychological adjustment to illness and family relationships [5, 6]. Indeed, a cancer diagnosis reverberates throughout the family system and often necessitates significant role changes among its members [7–9].

Marriage is one aspect of family functioning that has been the focus of recent studies among adults with illness. Indeed, the relationships between illness, marital status, and marital quality or satisfaction are the focus of a recent comprehensive review [10]. Large-scale epidemiological studies have pointed to the general association between unmarried adults and elevated mortality risk [5, 11, 12], and other investigations have found that married adults are healthier [13] and live longer [14–16] than nonmarried peers. Although the focus of these studies has been on mortality risk, there is growing evidence that marital status and quality may be important correlates of psychological

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morbidity during illness [10, 17, 18]. Generally, adults who are married and those who have higher levels of marital quality report fewer psychological distress symptoms than adults who are single or less satisfied with their marriage.

This latter finding can be explained by the main-effect and stress-buffering models of social support [19]. The main-effects model postulates that high levels of support (e.g., from partners, friends, health care professionals) enhance adaptation regardless of stress; since being married is considered evidence of social support and not being married represents an absence of this type of support, we would expect married adults to demonstrate a higher level of psychological adjustment to illness. The stress-buffering model posits that the detrimental effects of stress are attenuated by social support [20], thus suggesting that a more positive (but not negative) marital relationship would buffer the deleterious effects of illness and be related to a higher level of psychological adaptation.

Currently, it is not known whether the pattern of findings described above apply equally to women and men. For instance, does not being married or having a marital relationship low in quality differentially affect the psychological adjustment of women and men with cancer? Although women with illness report more anxiety and depression than their male counterparts [21, 22], these differences may dissipate in marriages of high quality [23]. However, as noted by Burman and Margolin [10], no consistent patterns have been identified regarding the role of gender in examining the relationship between marital variables and adjustment to illness.

In light of the possible relationship between marital variables and psychological adjustment to illness, the present study addresses three general questions that are pertinent to the functioning of adults with cancer. First, in consideration of the main-effect model of social support, is marital status associated with general and illness-specific psychological adjustment of adults with cancer? Second, in consideration of the stress-buffering model of social support, are married adults with cancer who report low marital quality especially vulnerable for general and illness-specific adjustment problems compared to their happily married counterparts? Third, does marital status and/or quality differentially affect women and men with cancer?

METHOD

Subjects

Participants were 86 married (53 female, 33 male) and 46 unmarried (29 female, 17 male) adults with cancer who participated in a larger study on psychological adaptation to illness [24]. All unmarried adults (50% single, never married; 46% separated or divorced; 4% widowed) were not living with an adult companion at the time of assessment. Married adults had a mean marriage duration of 19.38 years (SD = 12.23). Most participants were white (89%) and middle-class (81%) [25]. Mean duration of cancer was 25 months, and all adults in this heterogeneous sample were receiving active treatment for cancer. Cancer types represented in this study (listed in descending order of frequency) included breast, non-Hodgkin's lymphoma, leukemia, Hodgkin's disease, colorectal, melanoma, and testicular.

The two groups did not differ significantly on several demographic variables including socioeconomic status, education level, illness duration, and cancer treatment history (all p values were greater than 0.05). However, there was a significant between-groups effect for age, $t(130) = 4.80$, $p < 0.001$. Mean age was 36.91 (SD = 11.19) for the unmarried sample and 46.41 (SD = 10.64) for the married sample.

Procedure

All adults receiving treatment for cancer at a large Southeastern university medical center during a 14-month period were asked to participate in this study. Contact with prospective participants was initiated by telephone during the week preceding their scheduled oncology clinic appointment. Participation rate