



Cancer Fatalism and Psychological Well Being Among Cancer Patients

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ABSTRACT

There is much interest in whether belief system influences on Psychological condition of patients, the present study aims to study the influence of cancer fatalism on Psychological well being among cancer patients. By using descriptive research design data is obtained from 80 cancer patients from various hospitals in and around Bangalore city by using Cancer fatalism scale and Psychological well being scale. The findings indicate that there is a significant impact of fatalism on Psychological well being of cancer patients, in which Patients with low degree of cancer fatalism have shown a low level of Psychological well being and patients with high degree of cancer fatalism have shown higher level of Psychological well being.

KEYWORDS : Cancer fatalism, Psychological well Being and Cancer patients

1. INTRODUCTION:

The incidence and prevalence of cancer is rapidly increasing in the developed and developing countries. More than 10 million people are diagnosed with cancer every year. It is estimated that there will be 15 million new cases every year by 2020 (Horton, 2006).

One's belief system would influence greatly on health behaviour, Health beliefs differ from culture to culture, and In India beliefs are usually influenced by cultural and religious values, which in turn influence health behaviour.

The health belief model has been used as a theoretical framework to study the Psychological well being and other health related behaviours. The model stipulates that health related behaviour is influenced by a person's perception of the threat posed by a health problem and by the value associated with his or her action to reduce that threat (Champion et al, 997).

1.1 Cancer Fatalism

Cancer fatalism, the belief that death is inevitable when cancer is present has also been identified as a barrier to participation in cancer screening, detection and treatment. Cancer fatalism is believed to be the result of cultural, historical and socioeconomic factors that have influenced the lived experience of African-Americans (Powe, 1996).

Studies have revealed that fatalism may be a deterrent to participation in health promoting behaviours. Fatalism is the belief that all things in the world are under the control of some invisible force, and we are powerless to do anything about it. Fatalism is in general the view which holds that all events in the history of the world, and, in particular, the actions and incidents which make up the story of each individual life are determined by fate (Knight, 2003).

Fatalism is the belief that situations, such as illnesses or catastrophic events, happen because of a higher power (such as God), or they are just meant to happen, and cannot be avoided (Talbert PY, 2008). Indeed, fatalism has a strong tie with religion. Religious beliefs are particularly dominant among Indians, and together with a passionate confidence in God are such beliefs in fatalism, magic, witchcraft, and demons. Although Hindu's, Christianity and Islam have replaced traditional religions, the thoughts of the people about life, and their attitude to it, are still shaped by the old worldview. They exhibit this in their day-to-day interpersonal interactions (Jegade, 2002). These beliefs therefore remain, even in educated people long after their possible conversion to other religion. As a result, fatalism remains a part of the average Indian's worldview. Worldview may be defined as the mental grid through which one sees the world (Sarma, 2007). Cancer fatalism is a situational manifestation of fatalism in which individuals may feel powerless in the face of cancer and may view a diagnosis of cancer as a struggle against insurmountable odds (Powe & Johnson, 1995). This study therefore seeks to understand the perception of their own beliefs and its influence on their Psychological well being.

If we are to develop materials for educational intervention, they have to be culturally sensitive as the goal of such a drive will be to increase cancer knowledge, improve participation in cancer screening etc people belief system would be having greater influence on their perception of illness.

Health beliefs and fatalism have been studied in various populations as means of identifying other strategies to help promote positive health behaviors, such as cancer screening. There is limited information concerning such a study in India.

1.2 Health belief model

The Health Belief Model (HBM) is by far the most commonly used theory in health education and health promotion (Glanz, Rimer, & Lewis, 2002). The HBM is a method used to evaluate and explain individual differences in preventative health behavior (Janz et al, 2002). The HBM has had the greatest influence in research related to prediction associated with cancer screening behaviors; several studies have used the HBM to understand cancer screening behaviors. The HBM model subscales measure six concepts, including perceived susceptibility, perceived seriousness, barriers, benefits, health motivation, and confidence (Champion 1999).

1.2.1 Perceived susceptibility

As the first component of the HBM, perceived susceptibility is defined as a subjective perception of the risk of an illness. One's belief regarding the chances of being diagnosed with a medical condition can be applied by defining populations at risk and risk levels (Janz et al., 2002). Individual risk may be based on personal characteristics or behavior. Comparisons of perceived susceptibility with action risk can also be conducted (Janz et al., 2002). Related to cancer screening behaviors, perceived susceptibility may include the risk of a cancer diagnosis in the long term or immediate future.

1.2.2 Perceived severity

Perceived severity, formerly called perceived "seriousness" is the second construct of the HBM. Perceived severity speaks to an individual's belief about the severity or seriousness of a disease and the sequence of events after diagnosis and personal feelings related to the consequences of a specific medical condition (Janz, Champion, & Stretcher, 2002). Possible medical consequences may include death, disability, and pain; possible social consequences consist of effects on work, family life, and social relations (Janz et al., 2002). The combination of perceived susceptibility and perceived severity has been labeled perceived threat.

1.2.3 Perceived benefits

The construct of perceived benefits is a person's opinion of the value or usefulness of a new behavior in decreasing the risk of developing a disease. Also termed as perceived benefits of taking health action, the attitudes of health behavior changes are reliant on one's view of the health benefits for performing a health action (Janz et al., 2002).

1.2.4 Perceived barriers : Perceived barriers refer to the potential negative aspects of or obstructions to taking a recommended health action. This is the belief about physical and psychological costs of taking health action (Janz et al., 2002). An internal cost benefit analysis occurs, weighing the health action's expected effectiveness against perceptions that it may become an obstacle. Potential barriers may include financial expense, danger, pain, difficulty, upset, inconvenience, and time-consumption (Janz et al., 2002). Perceived barriers to performing cancer screening behaviors were emotional, social, and physical. Some of these barriers include difficulty with starting a new behavior or developing a new habit, fear of not being able to perform BSE correctly, having to give up things in order to do BSE, and embarrassment (Umeh & Rogan-Gibson, 2001).

1.2.5 Self-efficacy

Self-efficacy was added to the original four beliefs of the HBM in 1988 (Rosenstock, Strecher, & Becker, 1988). Self-efficacy is the belief in one's own ability to do something (Bandura, 1977). If a person believes a new behavior is useful (perceived benefit), but does not think he or she is capable of doing it (perceived barrier), chances are that it will not be tried.

1.2.6 Cues to action

Cues to action, formerly known as motivation, are events, people, or things that move people to change their behavior. Examples of cues include media reports about preventing cancer, illness of a family member, and perceived benefits (Graham, 2002).

Indian people are strongly dependent on religious beliefs and their perception of their problem in turn influences on their Psychological condition, hence a researcher intended to understand the association of Cancer fatalism belief on the level of Psychological well being among cancer patients.

1.3 Objective of the study:

To study the influence of cancer fatalism on the level of Psychological well being among Cancer patients.

1.4 Hypothesis:

There is a significant influence of cancer fatalism on the level of Psychological well being among cancer patients

2. Methodology

This study employed a descriptive survey design, with cancer fatalism and Psychological well being operationalized by the participants' responses to Powe's Cancer Fatalism Scale and Psychological well being inventory respectively.

The study evaluated the effects of cancer fatalism on the level of Psychological well being among Indian women. The Independent variable was Cancer fatalism. The dependent variable was the level of Psychological well being.

2.1 Data collection

Purposive sampling was employed in recruiting 80 women participants aged between 30 and 60. The choice of purposive sampling technique "ensures that only elements relevant to the research are included and guarantees that extra care is taken to select those elements that satisfy the requirements of the research" (Nworgu, 1991). Informed consent was obtained and participants were assured confidentiality of responses. Participation meant responding to a questionnaire soliciting demographic information as well as the the Powe Cancer Fatalism Scale and the Psychological Well Being Inventory.

2.2 Measures

2.2.1 Powe Cancer Fatalism Scale: Participants' level of cancer fatalism was assessed with the Powe Cancer Fatalism Scale (Powe, 1995). The Inventory is a 15-item questionnaire based on the philosophic origins and attributes of cancer fatalism (fear, predetermination, pessimism, inevitable death), with a Yes or No response. Each "Yes" response was scored as one point and a "No" response as zero, giving the possible range of scores from 0 to 15. Higher scores on the Powe Scale reflect higher degrees of fatalism. A score of zero to five indicates a low degree of fatalism, scores from six to ten indicate a moderate degree of fatalism, and scores from eleven to fifteen reflect a high degree of fatalism. In a study aimed at differentiating high-

er versus lower levels of cancer fatalism among a sample of African American women, Powe (2001) selected a mean score of 8 as a cut-off point, coding scores of 0 to 8 as low cancer fatalism and scores 9 to 15 as high cancer fatalism. In this study, a cut off point was used to classify participants as "High" and "Low" Cancer Fatalism individuals. Participants with scores equal to or greater than 8 were categorized as "High Fatalism" individuals and those whose scores on this scale were below 8 were classified as "Low Fatalism" individuals.

2.2.2 Psychological well being:

This scale was developed by Sudhabhogle and Indira jai Prakash (1995) was used to assess the Psychological wellbeing levels of the subjects. This questionnaire contains 28 items, for which the subjects have to put the right mark for either of two options "YES" or "NO". Some of the items were designed to elicit YES responses and some of the items were designed to elicit NO responses. The 28 items in the questionnaire was divided into 13 factors, which will contribute to the Psychological wellbeing of the individuals. They are meaninglessness, Somatic symptoms, self esteem, positive effect, daily activities, life satisfaction, suicidal ideas, personal control, social support, tension, Wellness, General efficiency and satisfaction and the total score of this 13 factors gives the total score for Psychological wellbeing. The maximum and minimum scores are 28 and 0 respectively. A high score indicates high level of Psychological wellbeing and a low score indicates a low level of Psychological Wellbeing.

3.0 Results and analysis

In the current study the researcher intended to examine the influence of cancer fatalism on the level of Psychological wellbeing, the data is obtained by using an interview schedule, Cancer fatalism scale and Psychological well being Questionnaire and analysed as follows to test the hypothesis,

Table 1: Shows the Mean, SD and t ratio on the level of Psychological wellbeing of two groups who have high cancer fatalism and low cancer fatalism

Variable	Psychological wellbeing			t-ratio
	N	Mean	SD	
Low cancer fatalism	40	9.2	2.8	10.3**
High cancer fatalism	40	13.4	3.3	
Total	80			10.3**

Table shows The mean, SD and t ratio on the Psychological wellbeing of two groups i.e with high cancer fatalism and with Low cancer fatalism, The sample group which has high cancer fatalism has obtained a mean score of 13.4 on Psychological Wellbeing with its SD of 3.3 and the sample group with low cancer fatalism has obtained a mean of 9.2 with its SD of 2.8. It clearly indicates that the sample group who have higher cancer fatalism obtained the greater mean score compared to the sample group who have lower cancer fatalism.

3.1 Hypothesis Testing

In the present study it is hypothesized that cancer patients with high cancer fatalism will report greater Psychological wellbeing compared to the patients who have low cancer fatalism. Table 1 show The Mean, SD and the t ratio on Psychological wellbeing scores of two groups, in which clearly indicates that the sample with high cancer fatalism have got greater mean score compared to the sample who had lower cancer fatalism, In order to find out the level of significant mean difference, an independent sample t test was calculated and the obtained t ratio is 10.3, which is significant (P value >0.01). Hence the findings clearly show that the sample group who had high cancer fatalism exhibited greater level of Psychological wellbeing compared to the sample that had low cancer fatalism. This finding is supported to the hypothesis of this study that there is a significant influence of cancer fatalism on the level of Psychological well being among cancer patients.

3.2 Conclusion:

The findings of the study are as follows

There is a greater level of Psychological wellbeing among cancer patients who had high cancer fatalism compared those who had lesser fatalism.

3.3 Limitations and suggestions

The present study consists a small sample size, hence the generalization of the findings are restricted.

The present study includes only women patients.

REFERENCES

- Akhigbe AO, Omuemu VO.(2009) Knowledge, attitudes and practice of breast cancer screening among female health workers in a Nigerian urban city. *BMC Cancer*. 2009 Jun 25;9:203 | Akhigbe AO, Igbiniedion BO, Ogbuide UO & Ikubor JE (2009) Final year medical students' knowledge about breast cancer risk factors and screening methods. *Journal of Medicine & Biomedical Research* 2009; 8(1): 49-57 | Akhigbe AO & Igbiniedion BO (2010) Pattern of utilization of mammography: experience from Benin City, Nigeria. *Nigerian Journal of Surgical Sciences*. 2010; 20(2):61-68 American Cancer Society. *Cancer Statistics*. CA: Am Cancer J Clin 2002; 52: 10-11 Atoyebi OA, | Atimomo CE, Adesanya AA, Beredugo BK, da Rocha-Afodu JT: An appraisal of 100 patients with breast cancer seen at the Lagos University Teaching Hospital. *Nig. Qt J. Hosp. Med*. 1997; 7: 104-8. www.intechopen.com | Effects of Health Belief and Cancer Fatalism on the Practice of Breast Cancer Screening Among Nigerian Women 87 Champion, V. (1993). Instrument for breast cancer screening behaviors. *Nursing Research*, 42, 139–143. | Champion, V., & Menon, U. (1997). Predicting mammography and breast self-examination in African-American women. *Cancer Nursing*, 20, 315–322. | Champion VL (1999). Revised susceptibility, benefits, barrier scale for mammography screening. *Research in Nursing & Health*, 1999, 22, 341-348 | Corsini, R. J. (1999). *The dictionary of psychology*. Philadelphia: Taylor & Francis Group. | DeVellis, RF (2003). *Scale development: Theory and applications* (2nd ed.) Thousand Oaks, California:Sage. Glanz, K, Rimer, BK, Lewis, FM.. Eds. *Health behavior and health education: theory, research, and practice*. 3rd Edition. Jossey-Bass publishing, San Francisco, CA. 2002. | Graham, ME (2002) Health beliefs and self breast examination in black women. *J Cult Divers.*; 9(2):49-54 | Horton J (2006). Breast cancer in 2020: What can we expect? *Cancer Detect Prev*, 30, 109-110 | Janz, N. K., Champion, V. L., & Strecher, V. J. (2002). The Health Belief Model. In K.Glanz, | B.K. Rimer, & F.M. Lewis (Eds.), *Health Behavior and Health Education: Theory, Research, and Practice* 3rd Edition (pp.45-66). Jossey-Bass. San Francisco, CA 2002. | Jegede, AS (2002) The Yoruba Cultural Construction of Health and Illness *Nordic Journal of African Studies* 11(3): 322-335 | Knight, K. (2003). *The Catholic Encyclopaedia* (Vol.5), New York: Robert Appleton. | Nworgu BG (1991). *Educational Research: Basic Issues and methodology*. Wisdom Publishers Ltd. Ibadan | Odusanya OO, Tayo OO (2001) Breast cancer knowledge, attitude and practice among nurses in Lagos, Nigeria. *Acta Oncol*. 2001; 40(7):844-848 | Okobia MN, Bunker CH, Okonofua FE, Osime U. Knowledge attitude and practice of Nigerian women towards breast cancer; a cross sectional study. *World journal of surgical oncology*, 2006; 4:11. | Powe BD (1995) Fatalism among elderly African Americans: Effects on colorectal screening. *Cancer Nursing*, 18(5), 385-392. | Powe BD & Johnson A (1995) fatalism among African Americans: philosophical perspectives. *J. Religion Health*. 1995;34(2):18-21 | Powe BD (1996) Fatalism among African Americans: A review of the literature. *Nursing Outlook*, 44(1), 18-21. | Powe BD (1997) Cancer Fatalism — Spiritual Perspectives *Journal of Religion and Health*, 36(2), 135-144 | Powe BD (2001) Cancer fatalism among African American women: predictors of the intensity of the perceptions. *J Psychosoc Oncol*. 2001; 19(3/4):85-96 | Powe BD & Finnie R (2003) Cancer fatalism —the state of the science. *Cancer Nursing*, 2003;26(6):454-465 | Rosenstock, I.M, Strecher, V.J., & Becker, M.H. (1988). Social learning theory and the Health Belief Model. *Health Education Quarterly*, 15 (2), 175–183. | Sarma BA (2007) Belief and Character: Theology and Ethics of Road Safety in Nigeria. *TCNN Research Bulletin* 48,13-27. www.intechopen.com Mammography – Recent Advances 88 | Talbert PY (2008) The Relationship of Fear and Fatalism with Breast Cancer Screening Among a Selected Target Population of African American Middle Class Women *Journal of Social, Behavioral, and Health Sciences*, 2008, 2, 96-110 | Umeh K, Rogan-Gibson(2001) J Perceptions of threat, benefits, and barriers in breast self examination amongst young asymptomatic women *British Journal of Health Psychology* (2001), 6, 361–372 |