

SELF-DISCLOSURE OF ADULT CANCER AND
OTHER CHRONICALLY ILL PATIENTS

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DEDICATION

This work is dedicated to the person whose sustaining support made its completion a reality--my husband, C. J.

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CHAPTER 1

INTRODUCTION

The concept of self-disclosure is believed to be one of the ways human beings share knowledge of their individual selves with one another. The concept is believed to correlate positively with a person's level of wellness and ability to cope with disease. Trust is thought to be an integral factor within the concept. The concept is also assumed basic to the establishment of meaningful interpersonal relationships. If the assumptions for the concept are true, then the concept has relevance for health care professionals. Communication between health care workers and people who seek their services is of considerable importance if mutual understanding of therapeutic goals is to be achieved.

When a person has a chronic illness the establishment of a therapeutic interpersonal relationship becomes a necessity if all parties are to share the responsibility in managing an illness that affects every facet of the patient's life. Although the concept of self-disclosure has been studied by several investigators since the middle of this century, there is a dearth of reported research on

the concept as it is related to persons who have chronic disease. In the public mind cancer and other chronic diseases are often associated with disability and death. Because of the emotional impact of these aspects both health care professionals and the lay public often experience difficulty in fostering meaningful interpersonal relationships with persons who have chronic illnesses.

Today much is being written and discussed concerning the quality of life for persons who have chronic disease. Such discussions are taking place among health care providers and the public alike. Patients are beginning to demand more accountability and concern from those who serve in the health care system, and they are beginning to seek a voice in decisions that affect them. Thus, it is believed communication which is fostered in an atmosphere of reciprocal trust and respect will add a measure of those intangible items most persons agree are found in quality life--dignity, self-respect, and an opportunity to be involved in decision making with others.

Studies have suggested a relationship may exist between physical illness and emotional well-being. Although physical and emotional well-being may not always be related, there exists empirical evidence that one often contributes to, or hinders, the other. With the exception

of a few studies, the concept of self-disclosure has not been examined in relation to persons with known physical illness. This study was undertaken to add to the existing data about the concept by establishing a self-disclosure index among a group of persons who had cancer and other chronic illnesses.

Statement of Problem

The problem of the study was to determine if a difference existed between the level of self-disclosure of adult, nonhospitalized cancer patients and adult, nonhospitalized patients with other specified chronic physical diseases.

Statement of Purposes

The purposes of the study were to:

1. Obtain a self-disclosure, descriptive index of adult cancer patients who were nonhospitalized.
2. Obtain a self-disclosure, descriptive index of adults who had specific diseases other than cancer and were nonhospitalized.
3. Compile a composite of the self-disclosure, descriptive index of nonhospitalized chronically ill adult patients.

4. Compare the self-disclosure, descriptive index of adult, nonhospitalized cancer patients to the index obtained from nonhospitalized adults who had other specific chronic physical diseases.

Background and Significance

Human beings have found communication to be necessary in almost every endeavor they undertake. Communication is the basis for social relationships. Communication systems can be relatively simple or, conversely, very complex. Even the seemingly, relatively simple communication which takes place between two people may be complex. This complexity is well illustrated by Heider's p-o-x model (Ackoff & Emery, 1972). In this model, p represents a message sent by one person to another (o) about something (x). What complicates the apparent simplicity is the consideration of the eight properties inherent in the communication: p's attitudes and beliefs about x and o, and o's attitude and beliefs about p and x. However, that people have not been dissuaded from establishing human relationships despite the complexities involved is evidenced by the fact few are able to live in total isolation for very long. Socialization is realized by most to be a desirable state, and anything that threatens to

bring about social isolation is feared by most people. Hyman (1972) concluded the social isolation phenomenon has a direct relationship to the effect of medical treatment on the stroke patient, and Vignos, Thompson, Katz, Moskowitz, Fink, and Svec (1972) stated the arthritic patient's social adjustment is an important factor in adaptation to the impact of that disease. Singer (1973) found persons who have Parkinson's disease are more likely to engage in solitary activities and, therefore, may be more socially isolated than others of a comparable age.

The fear of loneliness and abandonment, that is, social isolation, concomitant with the fears of pain and death are factors that cause people to view cancer with horror (Krant, 1976). That such fear and dread is not confined to the relatively uneducated is attested to in the literature written by and for nurses, physicians, and other health care workers (Klagsburn, 1970; Schnaper, 1977). Madden (1977) postulated the reason for rotating nurses on units not totally comprised of cancer patients is because the nurses are not comfortable around such patients. Rosenbaum (1975) suggested such patients serve as a reminder of the nurses' own unresolved feelings about death. Fiefel (1972) and Schnaper (1977) wrote some physicians unconsciously view cancer patients as a threat

to their omnipotence. Not only because cancer is so frequently a terminal disease, but also because of an unconscious fear, the physician may expedite death through the medical orders. The frustration of not being able to produce a cure in people who have a variety of chronic physical illness was also discussed by Duff and Hollingshead (1968).

A study by Hayes (1976) showed although cancer patients placed a high premium on an effective physician-patient relationship, 35% reported little to no truthful conversation with their doctors; that is, they felt their physicians told them little to nothing regarding their prognosis. Duff and Hollingshead (1968) found these same complaints prevalent in their study of patients who suffered a variety of acute and chronic illnesses. In drawing conclusions about the apparent lack of physician-patient communication, Hayes (1976) indicated the type training physicians receive in their professional programs as being at least partially responsible.

Studies (Parsons, 1977; Wiener, 1975), articles (Benoliel & Crawley, 1977; Reading, 1977), and nursing texts (Bouchard & Owens, 1976; Luckman & Sorensen, 1974) have dealt with the guilts and numerous fears that inundate many patients and their families when a diagnosis of

chronic illness is made. However, Buehler (1975) found hope to be the more predominant feeling in a group of 24 radiation patients who ranged in age from 17 to 50 years. Books are being published that provide guidelines for health care professionals, as well as the lay public, to assist people who have chronic illness to participate in the activities of living as fully as possible (Rosenbaum, 1975; Strauss, 1975).

Chronic disease is expensive in terms of emotions. These emotions, if too intense and prolonged, can disrupt or threaten relationships with those from whom the patient received primary support--the family (Dorn, 1976). In order to dissipate some of the intensity of the patients' need for emotional support, groups such as Make Today Count have been organized for cancer patients (Peelman, 1977); and ostomy clubs and diabetes groups serve these same functions for patients who have these chronic conditions. Chronic disease is also monetarily expensive. Patients and their families frequently fear the financial difficulties the illness may bring (Donovan & Pierce, 1976; Strauss, 1975). The American Heart Association (1978) indicated cardiovascular disease would cost the nation an estimated 28.5 billion dollars in 1978 and other hidden costs, for example, production know-how, personnel training

and development, and labor turnover, are difficult to determine.

When people suffer chronic illness, emotional stress often results both from fear of how the disease process may affect the control they have over their own lives as well as the lives of their families. These fears may influence the trajectory of the illness. Rosenbaum (1975) cited numerous case studies where he believed this to be true for cancer patients. Strauss (1975) discussed the same kind of fear and its relation on the effect of the illness for those who have a variety of chronic conditions. Selye (1976) affirmed his belief that a person's self-understanding

can--at least in some cases--help those whose bodily disease manifestations are due to unexplained mental tension and . . . failure to adjust ourselves correctly to life situations is at the very root of the disease-producing conflicts. (p. 406)

Jourard (1971a) stated "one's attitude toward life and self are factors both in the onset of illness and the recovery therefrom" (p. 76). Fox (1976) contended while certain personality characteristics may be found among those with particular disease processes, the support for such statements is weak. He maintained medicine should continue to concentrate on studies that can be better scientifically validated. However, the majority who study

and write about various disease processes take into consideration what Neuman (1974) has referred to as intra-, inter-, and extrapersonal factors. Neuman considers these factors to have a dynamic influence on a person's physiologic, psychologic, sociocultural, and developmental variables when stress producing agents are encountered. With the exception of those who concern themselves only with the physiological aspects of disease, most researchers and writers seem to agree the human body which is experiencing an illness needs to be treated as an integrated whole.

In further consideration of the mind-body concept of disease, Jourard (1971a) stated his belief that over adherence to confining social roles, to the exclusion of allowing the self to become known, leads to emotional and physical illness. He postulated this occurs through a process termed dispirituation. Bakan (1971) appeared to concur when he said that telic decentralization, self-alienation, is a source of human inability to cope with illness and disease. Illich (1976) maintained much of humanity's illness is fostered and preserved by technology and industrialization that has abolished our ability to be aware of, and capable of, caring for our own health-care needs. The willingness to know oneself, and its

relation to illness, is summarized by Selye (1976), "it is well established that the mere fact of knowing what hurts you has an inherent curative value" (p. 406). This phrase has special meaning for health care professionals. For if such professionals are able to learn what is hurting patients, they may be in a position to assist them in overcoming, or at least minimizing, the sources of their distress. Jourard (1971a) stated his belief that one of the best ways to learn what is hurting patients is to allow them to self-disclose to their physicians and nurses. He proposed professional training programs should include courses to teach the facilitation of disclosure, thereby eliminating the stiffling bedside manner often learned in many programs. He maintained the bedside manner often hinders meaningful interpersonal communication between patients and their professional caretakers, and denies patients the benefit of a continually updated diagnosis and plan of treatment as well as the empathic understanding to which they are entitled. Hayes (1976) and Krant (1976) appeared to support such a thesis, at least for physicians.

Evidence that the facilitation of self-disclosure has a place in nursing practice may be surmised from a cursory review of nursing texts (Donovan & Pierce, 1977;

Jones, Dunbar, & Jirovec, 1978) and the literature (MacElveen, 1976) that stresses the nurse's need to include patients in planning for their own care. Many readjustments are required of persons who have a chronic disease. Psychological readjustments are always required when the disease process forces a physical readjustment. However, a certain degree of psychological readjustment is frequently necessary before physical readjustment can proceed. It is believed that identifying values of personal relevance to the patient may facilitate a psychological readjustment. Thus, self-disclosure assumes a measure of importance when nurses take an initial patient history. Later, self-disclosure may contribute to the maintenance of an interpersonal relationship between patients and their nurses that may facilitate communication. Meaningful communication between patients and their nurses might encourage decision-making that is shared rather than autocratic (Houchbaum, 1976).

Self-disclosure has been studied in several countries, races, and among various age groups, but it has not been widely studied among persons with known physical illness. This study was designed to assist in establishing an index of self-disclosure of patients who had cancer and other specified chronic physical illness.

Hypothesis

Patients with a diagnosis of cancer do not demonstrate a level of self-disclosure that is significantly different from patients who have a diagnosis of other chronic and potentially debilitating diseases.

Definition of Terms

For the purposes of this study, the following terms were defined:

1. Active medical treatment--a prescribed protocol which required continual medical evaluation by the physician.
2. Adult--any person who was 18 years of age or older.
3. Cancer--the diagnosis of a chronic neoplastic disease.
4. Chronic disease/illness--any endocrine, cardiovascular, gastrointestinal, respiratory, or arthritic condition, renal disorder, Hansen's disease, or systemic lupus erythematosus, or neoplastic disease, that affected the subjects' lives to the extent they were receiving active medical treatment for the diagnosed problem
5. Continual medical treatment/supervision--the subject, due to the nature of the illness and the medical

protocol, was evaluated by the physician at least once each six months.

6. Patient--any subject who had a diagnosis of cancer or other specified chronic disease.

7. Self-disclosure--the willingness to communicate information to others so they are able to know what is of personal concern and value to the person imparting the information.

Limitations

The limitations of the study included:

1. The patients who had cancer were receiving treatment on different protocols as dictated by the type and site of their lesion(s).

2. The other chronically ill patients had a variety of diagnoses and were following a variety of medical protocols..

3. Both groups of patients had a wide variability in their symptoms during the time of the study.

4. Both groups of patients may have had a wide disparity in their annual incomes and their indebtedness.

5. Some subjects had multiple diagnoses.

6. The length of the illness/disease varied widely, both between and among the two patient groups.

Delimitations

The delimitations of the study included:

1. Only adult persons, 18 years of age and older, were included in the study. To be eligible for inclusion the subjects had to have attained at least their eighteenth birthday by the date of receiving the informed consent and introductory letter.

2. All subjects who had a diagnosis of cancer were receiving some form of active therapy and/or frequent reevaluation from the physician.

3. All other chronically ill subjects were under continual medical treatment for one or more of the following: Hansen's disease or systemic lupus erythematosus, arthritis, endocrine, cardiovascular, respiratory, gastrointestinal, or renal disease.

4. Subjects who had multiple diagnoses were categorized according to their primary diagnosis, that is, the one for which they were receiving active medical treatment.

Assumptions

For the purposes of this study, the following assumptions were made:

1. All human beings who are able to communicate

reveal themselves in varying degrees to people with whom they have contact.

2. Knowledge of personal values can be used as a referent for a decision-making process. .

3. Human beings value interaction with other human beings.

4. Truthful expression of personal values is encouraged by anonymity if the element of dependency is not present.

Summary

This chapter introduced the subject of self-disclosure in adult, nonhospitalized cancer and other specified chronic disease patients. Literature was cited which suggested significant communication between health care providers and those who suffer chronic physical disease can be used for improving the quality of life for such patients. Further, self-disclosure which adds to meaningful interpersonal communication has a place in the practice of all health care professionals, especially physicians and nurses. It was suggested disclosure first assumes an importance when patients' medical or nursing histories are obtained for the purpose of establishing goals as a basis for evaluating their health.

status, and later as a means of guiding them into more healthful living practices.

CHAPTER 2

REVIEW OF THE LITERATURE

Advances which have been made in medical science, especially since the middle of this century, have pushed the topic of chronic physical disease to the forefront of human thinking. Technical achievements have provided the medical world with a wide range of agents and mechanical devices to detect and treat human pathologies thought untreatable even a few decades ago. As health care professionals have learned to use these agents and devices, the consumers of the technical advances have both welcomed and voiced concern for the outcomes. Some feel the human element is being ignored.

Literature reviewed for this study of self-disclosure in patients who have cancer and other specified chronic diseases included writings and studies conducted by social scientists, behaviorists, and persons from the fields of medicine and nursing. Stress, excessive use of defense mechanisms, social isolation, and care versus cure are some of the topics which have been written about and studied in persons who suffer chronic illness. Although self-disclosure has not been widely studied in chronic

disease, investigation is beginning to be conducted in this area.

Self-Disclosure

Self-disclosure has been defined as the means by which one person willingly makes the self known to others (Jourard & Jaffe, 1970). The term self-disclosure was coined by Jourard, although others used terms such as verbal accessibility (Polansky, 1965) and social accessibility (Rickers-Ovsiankina, 1956) to describe what appears to be the same concept. However, in an extensive review of the literature Cozby (1973) found self-disclosure to be the term most frequently used in describing the phenomena whereby people purposely reveal personally relevant material about themselves. Further, the term self-disclosure has been used to refer both to a personality construct and a process of interaction with others.

Jourard (1964, 1971a) suggested the accurate portrayal of the self to others can be viewed as a criterion of a healthy personality, and that neurosis is related to inability to know one's real self and make the self known to others. Other psychologists have expressed the belief that self-knowledge is an important factor in the manner in which a person conducts his interpersonal, social relationships. For example, Roger's (1961) construct of

congruence included an accurate matching of experience, awareness, and communication which he contended was fundamental for successful living. He believed an accurate matching of experience and awareness allowed increased honesty between people who were trying to communicate. In studying self-actualization, Maslow (1968) stated

that fear of knowledge of oneself is very often isomorphic with, and parallel with, fear of the outside world. That is, inner problems and outer problems tend to be deeply similar and to be related to each other. (p. 60)

He concluded the person who has not accepted the self will feel compelled to censor communication with others and will use deceit and other defenses in order to protect the self-esteem. Fromm (1947), Riseman (1950), and Horney (1950) also addressed the tendency of people to misrepresent the self to others.

Factors in Self-Disclosure

Studies have been conducted to determine factors that appear to have relevance upon the amount and kind of information people reveal about themselves and to whom it is imparted. Some of the factors which have been studied in connection with self-disclosure are sex, age, race, and marital status.

Sex. Jourard and Lasakow (1958) reported females have higher disclosure scores than males. This finding has been replicated in a number of studies (Diamond & Munz, 1967; Hood & Back, 1971; Johnson, 1977; Jourard, 1961a; Jourard & Richman, 1963; Pederson & Higbee, 1969b). Jourard (1971a) hypothesized this difference is related to sex role differences in society. He believed men's roles require them to appear tough, objective, and emotionally unexpressive, while women are trained toward motherhood and a comforting function which allows them to give and receive more disclosure. Therefore, women become more "transparent selves"; that is, they know themselves better. In a study which lends support to this hypothesis of sex and role differences as they relate to self-image and possible disclosure, Back (1971) studied 502 males and females aged 45 through 70. His study supported that the men's personality tended to be more involved with their roles and that as these roles changed so did their self-image. While the women in the study also experienced role changes as they aged, their self-image did not decrease to the extent the men's did. In fact, as they aged the women reportedly felt they could be more accepted for themselves and not merely as persons related to a role.

Mothers, since they are women, are the target of more self-disclosure from their children than fathers (Jourard, 1957, 1959; Jourard & Lasakow, 1958; Littlefield, 1973; Rivenbark, 1971). This finding would appear to lend support to the thesis that females do disclose and receive more disclosure than males. Not all studies, however, have empirically supported women self-disclose to a significantly higher degree than men (Diamond & Hellkamp, 1969; Vondracek & Marshall, 1971; Weigel, Weigel, & Chadwick, 1969). However, no studies have been reported where males disclosed at a significantly higher level than females, a fact which seems to suggest there might be a difference in disclosure as it relates to gender. However, Henley (1974) and Derlega and Chaikin (1976) postulated greater female disclosure is related to American cultural norms rather than to biology; and this is in keeping with Jourard's hypothesis of sex role differences.

Age. As people grow from childhood into mature years their interpersonal relationships change and so too their targets of disclosure, that is, the persons to whom they purposefully share knowledge of themselves. In extrapolating data from several studies a continuum of disclosure over time, as well as to target persons, can be

proposed. In the child of less than 12 years of age mother appears to be the closest confidant, although disclosure to the peer group has a linear increase with age and with adolescence females begin to disclose more than males (Rivenbark, 1971; Skyepeck, 1971). In late adolescence and young adulthood disclosure to parents is reduced and is increased to the closest same-sex friend (Jourard, 1957, 1959; Jourard & Lasakow, 1958). As heterosexual relationships are begun and marriage undertaken the spouse becomes the closest confident, and confiding in the parents and closest same-sex friend decreases (Jourard, 1961; Jourard & Lasakow, 1958). Around age 40, disclosure to opposite-sex friend and spouse begins to drop off (Jourard, 1961, 1971c). However, in studying disclosure in white, male, coronary patients aged 38 through 60, Proffit (1974) found the patients' wives and closest opposite-sex friend remained as their greatest target for disclosure.

In studies including over 1,000 college students aged 17 through 55, Jourard (1961, 1971b) found 35% of the oldest females to be unmarried. These women also had substantially lower self-disclosure scores than the other women. This finding led him to suggest that unless these women had confiding relationships with people other than

the target persons mentioned on the questionnaires, they could be assumed to be relatively lonely people. From this finding he concluded knowledge of self-disclosure among older people might prove fruitful for research. Morievaki (1973) looked at a group of retired persons aged 60 through 84 years and found while self-disclosure was significantly related to conditions leading to roll loss it was not significantly related to psychological well-being. Johnson (1977), in a study of hospitalized patients 18 through 64 years and nurses 18 to 55 years and older, found while age was not a significant factor in either group, the older nurses did disclose less to their patients than nurses aged 18 through 34. Thus, studies which have examined the middle and older age group in connection with self-disclosure have not led to firm findings.

Marriage. Marital status and self-disclosure have been examined in several studies. Jourard and Lasakow (1958) demonstrated while marriage has an effect on disclosure, it is one of redistribution rather than increasing or decreasing the level of disclosure. They found that in marriage disclosure is directed toward the spouse while becoming more reticent toward others. This finding was

reconfirmed by Jourard (1961) and others (Johnson, 1977; Katz, Goldston, Cohen, & Stucker, 1963; Proffit, 1974). Jourard's (1961, 1971b, 1971c) tentative conclusion that disclosure in those of mature age decreases to all target persons, including the spouse, was based in part on his studies of age as a dependent variable. The results of Morievaki's (1973) study of disclosure and interpersonal relationships in the elderly suggested support for such a thesis. However Johnson's (1977) study, and especially Proffit's (1974) study offered contrary findings.

Several researchers have studied self-disclosure and marital satisfaction. While some studies have shown support for the theory that those who disclose more also find more satisfaction in the marital relationship, others have not. Levinger and Senn (1967), and Burke, Weir, and Harrison (1976) found disclosure tended to be related to marital satisfaction, but Shapiro and Swensen (1969) found no such relationship. Katz et al. (1963) found a relationship between marital satisfaction and the amount of disclosure for men but not for women. Further, the Katz et al. study showed men disclosed on topics related to anxieties and worries but not significantly on other topics. Conversely, Levinger and Senn (1967) found that correlation of marital satisfaction and disclosure was

related to greater disclosure of pleasant feelings. Although Burke et al. (1976) found husbands and wives who were more likely to disclose reported greater marital and life satisfaction, the level of disclosure was not related to measures of mental and physical well-being.

Race. Ethnic origin is a variable that has been examined in several self-disclosure studies. Jourard (1957) and Jourard and Lasakow (1958) demonstrated White Americans, both male and female, disclose to a significantly greater degree to target persons than Black Americans. Littlefield (1973) and Diamond and Hellkamp (1969) confirmed this finding. In addition, Littlefield's (1973) study also included Mexican-Americans, and he found Blacks to be greater disclosers than Mexican-Americans. However, Jaffee and Polansky (1962) found no difference between disclosure levels of lower-class Blacks and Whites. Johnson (1977) also found no relationship between race and self-disclosure among a group of hospitalized Caucasians, Negroes, and Mexican Americans.

Interpersonal Correlates of Self-Disclosure. In an extensive review of the literature on self-disclosure Cozby (1973) found, in general, a low correlation between disclosure and personality traits. A positive

correlation between self-disclosure and personality traits was found in nine of the studies, a negative correlation in two, and a nonsignificant correlation in seven. However, many studies have examined such traits as trust, dependency, affiliation need, approval need, and the interpersonal correlates of liking, knowing, and reciprocity in conjunction with self-disclosure.

In discussing the motivational mechanisms in interpersonal process and self-disclosure, Taylor and Oberlander (1969) wrote that persons who have a high self-disclosure score can also be assumed to have a wide acquaintanceship with others and frequent social interaction which exposes them to relatively high social stimulus cues. They stated both high and low self-disclosing behavior is an outgrowth of a person's n-Affiliation (need Affiliation) motive. This n-Affiliation leads to social interaction that contains some verbal communication which is evaluated in terms of reward-cost criteria; if the evaluation is positive the individual tends to remain in the interaction and if negative to withdraw. These authors concluded perceptual responses are a joint function of information in the environment and within the organism and, therefore, are psychological rather than physical. They further concluded the psychological motivations should be focused on

intra-subject parameters as major determinants of perception and self-disclosure.

Burhenne and Mirels (1970) wrote that a number of self-disclosure studies utilizing the Marlow-Crown Social Desirability Scale (SDS) strongly suggested approval-dependent persons will attempt to ward off threats to their vulnerable self-esteem. Conforming, submissive, and conventional behavior patterns are utilized by approval-dependent persons, and such behavior patterns make these people less self-disclosing. Boshier's (1973) study appeared to strengthen this conclusion. He looked at a group of adult males' signature style and attitudes and suggested the more liberal a person was in his thinking the more he tended to adjust to a given situation, while the more conservative he was the less he self-disclosed.

Dependency. The element of dependency has been examined in several studies and can be inferred from others. Altman and Haythorn's (1965) experimental study of pairs of naval recruits who were isolated together for 10 days, thus setting up a situation for high mutual dependency, showed a significantly greater social interaction pattern than did control pairs. Although the control pairs were forced to spend considerable time together they were allowed access to other people.

Thibaut and Kelly's (1959) study suggested that in a first social encounter where dependency is not a factor, the participants will face one another with some formality and constraint lest future relationships prove unsatisfying. However, a total lack of dependency with little likelihood of future encounters often increases self-disclosure (Derlega, Wilson, & Chaikin, 1976; Murdoch, Chenowith, & Rissman, 1973; Taylor, Altman, & Sorrentino, 1969).

An interaction of power, dependency, and disclosure has also been demonstrated. In general it appears subjects will voluntarily disclose more to those whom they perceive as having more power than themselves, if the element of dependency is present. Slobin, Miller, and Porter (1968) found in a business organization workers disclosed more to their immediate superiors than to their immediate subordinates. Confirmation for this power-dependency phenomenon was also demonstrated in Proffit's (1974) and Johnson's (1977) studies. Proffit showed while hospitalized male patients disclosed themselves to a significantly lesser degree to their physicians and nurses than to other target persons, they still disclosed more to the physicians than to the less powerful nurses. Johnson's study showed to a

significant degree patients disclosed more to their nurses than the nurses to the patients.

Trust. Jourard (1964, 1971a, 1971b) repeatedly contended trust is an integral element in the concept of self-disclosure. Although Vondracek and Marshall (1971) found a nonsignificant relationship between interpersonal trust and self-disclosure, acceptance of the proposition the element is integral to the concept can be inferred from several experimental studies. Altman and Haythorn's (1965) study of naval recruits appears to demonstrate trust was elemental, as well as a high mutual dependency, in establishing social interaction and disclosing patterns. Other self-disclosure studies which have suggested support for the thesis include Rubin's (1975) study of disclosing to strangers, Jourard and Jaffe's (1970) study of an experimenter's closure of physical distance, and especially Jourard and Friedman's (1970) study of distance closure and touch.

Liking, Knowing, and Reciprocity. The phenomena of liking and knowing and the part they play in the reciprocity of self-disclosure have been examined in several studies. Jourard and Lasakow (1958) found disclosure to mother and father correlated significantly with liking.

Jourard (1959) further studied the liking phenomenon by having nine female, college of nursing faculty rank one another for liking and the amount of disclosure they had received and given to these colleagues. He found disclosure input and output was positively correlated with liking. This finding also lent support to the reciprocity hypothesis, that is, those who disclose more about themselves have more disclosed to them in turn. Other studies which have confirmed that liking for the other person is a factor in female self-disclosure are those conducted by Cozby (1972), Halverson and Shore (1969), Worthy, Gray, and Kahn (1969). In 1960, Jourard and Landsman replicated Jourard's (1959) study with a group of nine male graduate students. In this study a relationship between disclosure and liking was not obtained, although support of the reciprocity hypothesis was. Instead of liking, knowledge of the other was shown to be the factor that correlated with male self-disclosure. Further proof that liking was not significant to male disclosure was found in Ehrlich and Graeven's (1971) study of males who conversed with a male confederate on either high or low-intimacy topics. Liking was also studied by Pederson and Higbee (1969b). They used the same target persons as Jourard and Landsman (1960) and correlated this with 11 liking/disliking adjectives. They

found, for both males and females, liking was significantly related to disclosure only for father and opposite-sex friend.

A number of studies have been done which demonstrate support for the reciprocity hypothesis in disclosure. Jourard and Richman (1963) found pairing a low discloser with a high one, while not affecting the high discloser's output, did increase the output for the low discloser. Other studies used a confederate who disclosed at either a high or a low level. All found a high-disclosing confederate elicited more disclosure from subjects than a low-disclosing one (Cozby, 1972; Erleich & Graeven, 1971; Jones & Archer, 1976; Jourard & Friedman, 1970; Murdoch et al., 1973; Rubin, 1973).

The Curvilinear Relationship. Though self-disclosure has been postulated as a means whereby people may decrease their alienation from self and others, it has been predicted a curvilinear relationship exists. Jourard (1964) stated too little or too much disclosure is inconsistent with an individual's goal of greater health. Levin and Gergen (1969) suggested disclosure indicates a desire for a closer relationship, yet a person who communicates a great deal about the self may be seen to lack discretion and be untrustworthy. Culbert (1970) and Derlega and

Chaikin (1977) in their papers on the interpersonal aspects of the concept reconfirmed this conclusion. Culbert (1970) maintained there are five dimensions in disclosure that have relevance to the curvilinear relationship: (a) the appropriateness of the disclosure, (b) the motivation prompting it, (c) the timing of its being made explicit, (d) the tense of the disclosure, and (e) the communicator's desire or intention in making it known. Derlega and Chaikin (1977) wrote concerning the dimensions of breadth and depth of disclosure as having a bearing on both reciprocity and the curvilinear relationship. Derlega and Chaikin stated these dimensions of disclosure are the control over privacy a person tries to maintain in any interpersonal situation.

Although the literature appears to justify the hypothesis of a curvilinear relationship in disclosure it has not been strongly supported. In trying to demonstrate it, Levin and Gergen (1969) found instead the more information revealed the greater the amount returned. However they did show their subjects revealed proportionately less as their partners (the researcher's confederates) revealed more. Cozby (1972) also did not find a curvilinear relationship, but he too found reciprocity to be a less powerful determinant of a subject's responses at levels of high intimacy.

However, Jones and Archer (1976) appear to have demonstrated the relationship in their study. They found when people become uncomfortable with a topic, while they may give the appearance of reciprocity (by increasing the breadth of disclosure) they are instead avoiding it.

Compendium

The patterns of self-disclosure, and the demographic variables of age, sex, race, and marital status, as well as the hypothesis of reciprocity have been documented in the literature as having a bearing on the concept of self-disclosure, and frequently as being positively correlated with it. Although self-disclosure in the mature age group has not been as widely studied as in adolescence and young adulthood, and contradictory findings have been reported, there is some evidence disclosure decreases with advancing age. There exists likewise even less written about the concept as it applies to those who have physical diseases and disabilities. In the following section the impact of chronic physical illness on a person's emotional and physical well-being is presented.

Chronic Disease

Persons with chronic illnesses are not only involved with the medical problems of their illness but also a large

spectrum of social, economic, and behavioral complications as well. These complications must also be examined within the context of total human involvement. For it is not the patient alone who suffers the condition but as Strauss (1975) has phrased it, the kinsmen as well; and as Feldman (1974) has written,

The intrusion of a significant illness, especially of a chronic and disabling nature is a major life crisis . . . [that] is "ongoing" in that there is little possibility of a complete return to the pre-morbid state. (p. 287).

Feldman urged research into the nature of sociocultural and behavioral aspects, which have not been studied with the same intensity as biological aspects, be accelerated for a holistic approach to the sick. Strauss and Feldman are not alone in calling for such a holistic approach to the problems associated with chronic disease. Other researchers and writers too have been concerned with the topic (Abram, 1972; Jourard, 1971a; Neuman, 1974; Shively, 1977; Wan, 1972; Zietlin, 1977).

People have striven for centuries to understand cause and effect of both physical and emotional illness. Physical illness, since the earliest recordings of history, has often been associated with impairments of cognitive and affective development. If precedents are needed in studying physical illness from something other than a

purely biological aspect, the world's literature is replete with them.

Stress

Stress, stressors, and their effects on all living organisms have been widely studied and written about. While a complete review of this large body of literature is not appropriate to this study it does have pertinence to both the physical and psychological aspect of physical breakdown. Selye (1973, 1976) is one of the foremost experimenters and writers on the topic. Although he maintained without stress life is not possible (1973), his extensive animal experiments have demonstrated that stress, and the hormones produced during excess stress, are capable of initiating physical pathology. This empirical evidence of the effects of stress possibly account for the noxious element of the phenomenon that have been emphasized in the literature (Donovan & Pierce, 1976; Jourard, 1971a; Neuman, 1974; Rapaport, 1962; Soloman & Amkraut, 1972).

In looking at life-crisis (stressors) as causative and/or contributory factors in physical disease, Holmes and Matsuda (1973) constructed a Schedule of Recent Experience (SRE) based on retrospective recall of a group of subjects' lives over a 10 year period. These events were

reported on the Social Readjustment Rating Scale (SRRS). By combining the results of the SRE and SRRS the researchers were provided with a life-crisis pattern. When the data were analyzed a positive relationship was found between illness and the magnitude of life-change events. Holmes and Matsuda hypothesized the greater the life change, the lower the resistance to disease. Prophit's (1974) study of myocardial infarction patients supported this hypothesis. Her data showed a consistent finding of recent life change prior to the subjects' cardiac events. Interestingly this change was one of accomplishment and success. Such a finding, however, is in keeping with Selye's (1976) General Adaptation Syndrome (GAS) theory. This theory states the effects of excess stress can stem from pleasant as well as unpleasant happenings. In Peterson's (1976) hypertension study, patients who had an increase of symptoms also showed a significant increase in the number of life-change events. Other studies have demonstrated a major life-change event appeared to precipitate or exacerbate a physical illness (Greene, W., 1976; Kavetsky, Turkevitch, & Balitsky, 1966; Petrich & Holmes, 1977; Soloman & Amkraut, 1972).

Psychological variables have been studied in cancer as possible predisposing factors and indicators of the trajectory of the disease for a number of years (Blumberg,

1954; Evans, 1926; Kissen, 1967; LeShan, 1959; Simonton & Simonton, 1974). Evans (1926) was one of the earlier writers who became interested in the psychosocial aspects of cancer. She reported a striking similarity of the psychosocial histories among 100 cancer patients. She suggested these people appeared to express their psychic energy outwardly into other people and activities, and when they lost these "other objects" they were unable to reinvest the released energy within themselves on a conscious level. She postulated this thwarted psychic energy retreated to the unconscious level where it combined with long ignored needs and emotions and resulted in the growth of malignancy. She proposed cancer was a symbol something had gone wrong in a person's life and was a warning readjustment of life style was necessary. Although Evans was writing only about the disease of cancer, Jourard (1971a) proposed poor social adjustment has applicability to all physical illness. He repeatedly stated his belief a person's over adherence to societal roles, to the exclusion of allowing the true self to be known, leads to emotional and physical illness. His term for illness induced by poor social adjustment was dispirituation (1971a). Bakan (1971) also addressed the issue of over adherence to societal roles as factors in illness. The hypothesis

being that when the self is not known alienation occurs which leads to mental and emotional distress. Such distress lowers the body's resistance to environmental stressors and culminates in physical illness. Selye (1973, 1976) is a strong advocate that the stresses of living, if people do not know themselves well enough to direct their lives into healthful patterns, leads to illness. Illich (1976) maintained much of humanity's illness is fostered and preserved by an environment of counterproductive technology and industrialization, that is, stress producing agents.

Psychological Correlates

While the majority of medical and nursing literature continues to be primarily concerned with the acute phase and the biological etiology and treatment of physical disease, there is beginning to appear literature which addresses the chronicity of many of these conditions. It is usually this literature which discusses the psychosocial aspects. Many of the studies and writings are based in theories found in the social and behavioral sciences. However attempts are being made to integrate some of these theories into the biological sciences for empirical validation. A substantial portion of this literature is concerned

with defense mechanisms and other psychological components of persons who suffer chronic disease.

Denial. Denial has been found to be a common defense mechanism used by those who have chronic diseases. Schnaper (1977) has even gone so far as to say "denial is hope, and, as such, is as important to cancer patients as are the narcotics they need for pain" (p. 1153). Others, however, have written denial is a hindering factor in seeking needed help and compliance with effective treatment regimens. Myers' (1977) report of a study conducted at a diabetic clinic found the trait of denial to be the single most common cause of patient failure to effectively control the disease. Vignos et al. (1972) found the personal adjustment of rheumatoid arthritic patients was strongly related to the degree both the patients and their families accepted or denied the diagnosis and treatment regimens. Berglund, Ander, and Lindstrom (1975) in a study of 50 year old males who were screened for hypertension in Sweden also found those who were untreated, and showed organ damage, tended to report fewer symptoms (denial) than treated hypertensives.

Emotional Suppression. The suppression of emotions has been postulated by several researchers and writers as being significantly correlated with several chronic diseases. In fact it has been implicated so often in cardiovascular disease it is thought by many to be the genesis of hypertension, a frequent forerunner of later multiple system complications if left untreated. Pilowsky, Spalding, Shaw, and Karner (1973) found among a group of male cardiac catheterization subjects a strong tendency to suppress emotions. Proffit (1974) in using the Personal Orientation Inventory (POI) in a study of male cardiac subjects found they tended to use suppression and denial especially in regard to the emotions of anger and aggression.

Kissen (1964) used the Maudsley Personality Inventory (MPI) to test for neurosis, and the Childhood Behavior Disorders (CBD) to test for emotional discharge on a group of male smokers, some of whom inhaled and some who did not. Subjects were general chest-unit patients and lung cancer patients. Results showed the poorer the ability to discharge emotions, the less tobacco smoke was needed to produce lung cancer. Kissen stated this finding was supported by empirical observation that nonsmokers who developed lung

cancer had the most difficulty of all lung patients in discharging emotion.

The difficulty in discharging emotions, especially anger, was also a strong suggestive finding in Bacon, Renneker, and Cutler's (1952) study of breast cancer patients who were less than 55 years of age. The over 55 age group were found to have better channels for affect discharge. This finding led these researchers to suggest while the older subjects may have been able to postpone the development of the disease through better channeling of their emotions, possibly they also had different psychological correlates. Bahnson (1976) too reported cancer patients repressed and denied the unpleasant effects of depression, anxiety, hostility, and guilt to a significantly greater degree than matched normal subjects.

Psychiatric Illness and Cancer. Several researchers found persons who suffered schizophrenia had a lower incidence of cancer than the general population (Brugmons, Verbruggen, & Dorm, 1973; Csatory, 1972). The hypothesis was while the disease protected the patients from having to face reality, the drug treatments (the phenothiazines), and the protected environment (the institutions) also interacted to spare them from developing malignancies.

However, Jambur and Burnstein (1977) found a greater incidence of cancer among their psychiatrically ill patients than normal controls. In a related study Brown, Varsamis, Toews, and Shane (1974) observed in follow-up studies of patients treated for a variety of neurosis, a disproportionately high number later developed tumors. These researchers suggested that depressive illness has an effect on the immune system which predisposes to neoplastic growth. Using Selye's GAS theory they described how cortisone, a hormone released at high stress levels, depresses the immune system.

Psychological Traits in Chronic Disease. Studies which have shown a correlation between cancer and the psychological traits of dependency, helplessness, hopelessness, and depression include Thomas and Duszynski (1974), Greene, W. (1976), Kissen (1964), Klopfer (1957), LeShan (1959, 1966), Schmale and Iker (1971). However, not all researchers have found these traits to be present in their subjects. For example, Buehler (1975) found hope to be predominant in a group of out-patient radiation subjects who ranged in age from 17 through 50. Parsons (1977) found out-of-hospital cancer subjects to be reality oriented as to diagnosis and prognosis and to have "a

veritable absence of emotional disturbances" (p. 23).

Leiber, Plumb, Gerstenzang, and Holland (1976) administered the Beck Depression Inventory (BDI) to a group of cancer patients and their spouses, three-fourths of whom were ambulatory and living at home. They found neither the patients nor their spouses were suffering severe depression. However, the female patients did show more depression than the male patients.

Patients who suffer chronic physical diseases other than cancer have also been shown to use denial excessively and to have an apparent difficulty in discharging emotions. This has been demonstrated in cardiovascular patients (Berglund et al., 1975; Hyman, 1972; Pilowski et al., 1973; Proffit, 1974), diabetic patients (Myers, 1977), respiratory disease patients (Kissen, 1964), arthritic patients (Vignos et al., 1972), and Parkinson's disease patients (Singer, 1973).

Psychological correlates which have been described in relation to patients who suffer coronary artery disease (CAD) are aggression, self-directedness, intense competitiveness, and obsessive ambition. Individuals who can be described by these character traits have been labeled type A personalities by Roseman and Friedman (1968). They developed the label after doing a longitudinal study of

3,500 males who had no history of CAD. Of that population, 250 later had a myocardial infarction and 70% of them were described as type A personalities. However, in contradiction to some of these personality characteristics, Proffit (1974) found her CAD subjects to be primarily other-directed and dependent personalities.

Social Isolation

Whether those who suffer chronic disabling diseases voluntarily withdraw from contact with others, or others withdraw from them is a subject which has received some study. Goffman (1963), a sociologist, has studied and written extensively how the possessor of a stigma (something which renders a person less socially desirable to others within a culture) and the "normals" who interact with him, proceed through the socialization process. Strauss (1975) also discussed the multiple problems of social interaction that face persons who have a variety of chronic physical illness. He used numerous case studies to illustrate the extent which financial problems, disease symptom control, and regimen management intrude upon both disease victims and their intimates as they attempt to normalize their situations.

In a study of stroke patients, Hyman (1972) found social isolation adversely affected that groups' medical

treatment. He concluded if the cause of social isolation is not discovered and treated, little can be done in rehabilitating stroke victims. Parsons (1977) in a study of intermediate stage, terminally ill cancer patients found while out-of-household contacts with family members had not changed since the beginning of the illness, contacts with people other than family had decreased. She concluded this decrease was indicative of friends and acquaintances withdrawal from the patients rather than the patients' withdrawal from them. As evidence for this conclusion, she found there was no decrease of contact between the patient and relatives who were not living in the home. This finding she said indicated that factors internal to the immediate household situation had not deteriorated. Singer (1973), in a study of Parkinson's patients, found those subjects were less likely to have a circle of close friends and more likely to engage in solitary activities than others of a comparable age.

The stigma of physical disability on a person's interpersonal relationships is evidenced by the establishment of both official and unofficial organizations. Such organizations are an attempt to educate the public, normals in Goffman's terminology, and the victims of physical stigma in ways to normalize their social interactions. A few

examples of officially recognized organizations are The American Heart Association, The American Diabetes Association, The American Cancer Society, and The American Lung Association. While these official organizations tend to have more people working for them who do not have physical disabilities, unofficial organizations are often founded and conducted by the disability victims or their intimates. Such organizations frequently have as their purpose the meeting of the immediate psychosocial needs of their members. Such groups have been organized for diabetics, cancer victims, the orthopedically disabled, those having various ostomies, and a host of other physical and emotional disabilities. Evidence that many are abandoned emotionally and physically as their disabilities progress and death is imminent is illustrated by an article titled "Death Companionship" (1975). This article described how a commercial business had been organized to provide companionship to the lonely and dying for a fee of \$7.50 an hour.

Self-Disclosure

Though few studies have been reported that examined self-disclosure in relation to physical disability, it is possible to draw some tentative conclusions from those that have been, as well as from the literature that has

been written about the psychosocial aspects of those who suffer chronic illness. Proffit (1974) studied self-disclosure in relation to male myocardial infarction patients and found a positive correlation between disclosure and cardiac readjustment. She found those subjects were fearful of expressing their feelings behaviorally; and their overcompensation scores, as evidenced on the POI, suggested they had feelings of low self-worth as well as being insensitive to their personal needs and feelings. These findings, and Proffit's interpretation of them appear consistent with the thesis of several writers who have stated, in essence, that people who repress their "selves," both from themselves and others, become self-alienated and less able to meet their own needs (Horney, 1950; Jourard, 1971a; Maslow, 1968; Rogers, 1961).

Proffit's (1974) findings of low self-worth and insensitivity to personal needs suggested cardiac patients might show a high state or trait-anxiety level if tested for this factor. Indeed, Johnson's (1977) study did show hospitalized patients and hospital-based nurses who evidenced a greater state-trait anxiety level did disclose to a lesser degree than less anxious patients and nurses.

Proffit (1974) reported her subjects had high dependency needs. Bahnson (1976), Green, W (1976), Wheeler and

Caldwell (1955), Blumberg (1954), and Thomas and Duszynski (1974) are among several who have written cancer patients reported being neglected as children, experienced a recent loss of love or affection, or showed other evidence of a need to be dependent. Such findings suggest these people may have had long-standing unmet dependency needs.

Another self-disclosure study involving persons with a chronic physical disability was Mesch's (1974) study of orthopedically disabled and nondisabled subjects. He found dyads composed of a disabled and a nondisabled subject disclosed to a greater extent on high-intimacy topics than either dyads of both disabled or both nondisabled subjects. However, the depth of disclosure was greatest in dyads where both subjects were disabled, while the nondisabled dyads showed the least amount of disclosure. These findings appear to demonstrate an attempt at disclosure control. Goffman (1963) referred to interaction between persons who have a stigma and those without a stigma as disclosure etiquette. Derlega and Chaikin (1977) appeared to be discussing this same phenomenon in what they termed dyadic boundary adjustment. In both cases it is a way whereby one of the parties attempts to exert control over information disclosed. Goffman, and Derlega and Chaikin might possibly agree the

orthopedically disabled subjects in the dyads were the controllers since the subjects in the nondisabled dyads revealed less than those in the other two groups. There was no significant difference found among any of the dyads on the measure of interpersonal attraction.

Compendium

The literature reviewed concerned with chronic physical disease appears to support the hypothesis physical illness may be due to, or at least its course influenced by stress; and that stress can have its genesis in a host of biopsychosocial factors. The influence of psychological traits and defense mechanisms have also been shown to be present and to adversely affect the outcome of medically prescribed treatments in persons who suffer a variety of potentially debilitating diseases.

The few studies which have explored self-disclosure in relation to physical illness and disability have tentatively shown the ability to disclose may be positively related to intra- and interpersonal control, and thus rehabilitation. The literature also suggested multicausal hypotheses in which autoimmune and psychological factors interact in varying degrees to form a predisposition matrix that leads to clinical manifestations of physical illness.

In the last section of this chapter studies and literature concerning the health care system and its effects on those who have chronic disease will be reviewed. The focus will be on physicians and nurses, and a holistic approach to patient care.

Chronic Disease Patients and Health Care Providers

Although technical expertise is no less important in the treatment of persons who suffer chronic disease than for those with acute conditions, a review of pertinent literature suggested cure often seems to take precedence over care. It has been implied health care workers who are primarily oriented toward cure of illness may be less therapeutic in their relationships with persons who have chronic debilitating diseases (Feldman, 1974; Jourard, 1960, 1971a; Kyle, 1964; Strauss, 1975). Schnaper (1972) wrote that a diagnosis of an incurable condition triggers a complex set of reactions that affects interrelationships between patients, their families, and health care providers; and when cure is not probable the quality of care becomes crucial.

Feldman (1974) proposed the traditional disease-oriented medical model may not be the best one within which to operate when working with persons who have chronic

disease. He suggested a new model with a primary concern for the behavioral and social impact of such illnesses might better confirm the value of these patients as human beings in the fullest sense. He stated such a model should, of course, encompass a goal-oriented approach that includes the necessary diagnostic, therapeutic, and rehabilitative services. Though Feldman was writing from a physician's perspective, Crayton, Brown, and Morrow (1978) emphasized these same sentiments in their report on a study of nurses' perceptions of cancer care and cancer patients. Other nursing writers have also addressed the issue that care of the patient assumes added impetus when cure is not possible (Abdellah, Beland, Martin, & Matheney, 1973; Kinlein, 1977; Little & Carnevali, 1976).

It has been commonly written that a person's premorbid personality and coping behaviors frequently contribute to the way in which physical illness is managed. Most writers on the subject agree people merely enlarge on behaviors and coping patterns they have used in the past, for social behavior is a learned technique. Health professionals also learn behavior and coping patterns which they utilize in their interactions with those who seek their help. Some writers have contended these behaviors are not always therapeutic. Jourard (1971a) was

particularly harsh in his condemnation of the professional manner some physicians and nurses adapt as character armor in protecting their selves, both from themselves and their patients. Abram (1972), Hayes (1976), Fiefel (1972), and Schnaper (1977) are among several whose writings appear to confirm such behavior is often detrimental to overall patient care.

Social Isolation

Social isolation, as another form of learned behavior, has been speculated about in writings by sociologists (Duff & Hollingshead, 1968; Goffman, 1963; Strauss, 1975), physicians (Feldman, 1974; Hyman, 1972; Schnaper, 1977), nurses (Madden, 1977; Parsons, 1977; Whitman & Lukes, 1975), and laymen (Corbet, 1978; Peelman, 1977; Photopoulos, 1976). In summary, the focus of such speculation is the chronically ill and disabled, even if they do not look particularly ill, are somewhat ostracized and avoided by the healthy. Such avoidance is not confined to the medically ignorant. Feldman (1974), Fiefel (1972), Krant (1976), Schnaper (1977) have written the chronically ill frequently pose threats to the physicians' feelings of omnipotence which lead some to adapt avoidance tactics with these patients. Duff and Hollingshead (1968) in an

extensive study in a large northeastern hospital in the United States found physician and nurse avoidance, especially of the chronically ill, to be common. Stockwell (1972), in a study of English nurses, found they avoided those they perceived as terminally ill as much as possible; and Madden (1977) and Klagsburn (1971) have reported such tendencies among American nurses. Perhaps an explanation for such findings may be found in the writings of Mereness (1966) and Brown (1966), though their articles predate those of Stockwell, Madden, and Klagsburn. They suggested nurses, too, like their colleague physicians enjoy the cure (technical) aspects of their duties more than the care aspects. For it is through participating in curing illness that nurses are able to fulfill their idealized self-image by having their efforts rewarded through favorable comments by physicians, and patients and their families. Perhaps, too, another explanation of the avoidance of the chronically ill can be found in examining the concept of empathy.

Empathy

The most common approach to the concept of empathy is to define it as a recognition and sharing of another's feelings. However, Kramer and Schmalenberg (1977a)

examined it from the point of view of a person's ability to take the role of others, and not only understand them better, but also be able to accurately predict their thoughts, feelings, and actions. It is this later type of empathy which is frequently thought of as being inherent in those who engage in the helping professions. Indeed Mehrabian and Epstein (1972) found the empathic tendency, rather than liking of the other person, was the major personality determinant of helping behavior. However, a study by Truax, Millis, and Altman (1974) found a group of registered nurses scored lower on a measure of accurate empathy than 10 other occupational groups with whom they were compared. The only group which was less empathic than the nurses was plant manufacturing supervisors. Duff and Hollingshead (1968) also reported that, for the most part, the anguish and fear of the patients in their study were outside the interests of the physicians and nurses; and that 71% of the nurses showed no evidence of empathy. Jourard (1971a) wrote at length how he felt self-disclosure could enhance the health professionals', especially nurses', abilities to be more cue sensitive (empathic) to their patients. He also reported (1971b) a study conducted by a student colleague indicated a positive relationship between disclosure

and empathy. While Kramer and Schmalenberg (1977a, 1977b) concluded from their study of new graduate nurses that the first job is a proving ground replete with informal testing processes which can be utilized as a basis for developing understanding and empathy that can extend to both co-workers and patients if properly managed.

Care Versus Cure

Lohr (1976) in a well documented overview of the impact of the health care system on the American public concluded many view the system as being unresponsive to those it would serve. Illich's (1976) book is a treatise on the subject. If the public is seeking more personalized care, a rhetorical question might be, why are health care professionals not as responsive to public demands as they might be. The answers are not easily forthcoming. Tradition, accelerated technology, inter- and intradisciplinary jealousies, and a host of current socioeconomic norms are so interwoven that extracting a common thread for exploration as to cause and effect is not possible; nor is it within the province of this study to explore such broad range implications. However, a brief look at some studies and writings that touch on a few of these topics is applicable to the subject of care versus cure.

Duff and Hollingshead (1968) found the physicians in their study knew little concerning their patients' way of life, that is, attitudes, beliefs, pattern of living; and that such histories were not viewed as significant by either the physicians or their patients. However, the investigators found, when they looked into the histories of these patients, a majority of their illnesses had strong social overtones. But both the physicians and their patients felt the physical examinations and the laboratory tests were more significant than personal medical histories.

Parsons (1977) in a study of the intermediate stage of terminal illness gave a good review of the literature which documented nurses, too, are more interested in a patient's physical care than they are in meeting emotional needs. This was evidenced by a dearth of nurse-patient communication on any level other than the physical. Hoover's (1975) study showed registered nurses from all types of educational programs preferred patients who required care involving technical skills. But, as the nurses' level of education increased so did their interest in patients who needed teaching and emotional support. Although Kyle's (1964) study did not differentiate educational levels of the nurses, she found cancer patients

who received supportive nursing care had fewer negative personality reactions and were able to make more realistic post-hospitalization plans than patients who received only physical nursing care. Craytor et al. (1978) also supported the hypothesis nurses are more comfortable in dealing with the physical than with the psychological problems of their patients. Although all the nurses in the study (LPNs, RNs, and RNs with graduate degrees) agreed physical and psychosocial needs were of equal importance, they also agreed psychosocial needs were less successfully met.

Possible interdisciplinary jealousy, lack of communication, and other sociocultural phenomena are given for conclusions Ambrose (1977) drew from his study which ranked nursing activities in order of importance by both physicians and nurses. The results showed significant physician-nurse agreement only on the physiological activities. These activities were ranked in first place by both nurses and physicians. While the nurses considered their involvement in patients' self-care and discharge to be of importance second only to their medically oriented activities, the physicians ranked these activities as the least important. Ambrose recommended attempts to resolve such priority disputes can and must be attempted through the various health-care associations and medical

and nursing schools if the objective of providing the public with comprehensive care is to be achieved. Krant (1976) in a study of several hundred patients and their families found while 98% believed they were receiving excellent technical medical care, over 60% said their human and psychological needs were not being met; and further that "when the going gets rough" they could not lean on their physicians (p. 270). He concluded such findings and statements indicate the educational goal of caring for the patient, in its full meaning of the phrase, has disappeared from medical training in favor of, or deference to, technical expertise and the great medical advances in cure and Hayes (1976) concurred.

Communication in Chronic Illness

Communication is not only a means of survival among the higher species of animal life but for human beings, with their extra-ordinate ability in this area, it is also that which sets them apart from other living organisms. Communication is not complete without one to receive the message another has sent. It has been commonly believed that communication breakdown is at the root of the majority of society's ills, both on a personal level and the complex international level. Thus, communication involves not only ability to send messages,

but also requires an accurate interpretation if a breakdown is to be avoided. History is replete with examples that people are more adept at sending than in accurately receiving communication. Health-care providers, because people are the commodity with which they work, need to be especially adept at communication skills. However, a large volume of literature exists which shows this is not always so. Davies (1976) wrote:

We have become experts in understanding cause and treatment for health problems, but we are novices in effectively obtaining the client's participation in using the knowledge to increase his level of wellness. Great technical strides may be irrelevant without commensurate understanding of the client and who he is. (p. 142)

Klagsburn's (1970) study is an example of how increasing the communication among the nursing personnel of a small nursing unit allowed nurses to become more sensitive to the patients and more free to communicate with them and involve them in decision making on their own behalf. The result was, as communication increased on all levels, that patients who had previously shown little interest in their surroundings became involved in their environment and resumed their dignity. That another's communication is not always easily understood has been further commented upon by Klagsburn (1971). He said a patient's often times muted communication requires the early establishment of a

trusting and caring relationship if severe problems are to be prevented from developing. He also said sensitivity to, and awareness of patients' communication may be that which invites them back into life. Jourard (1970, 1971a) said much the same when he wrote people live only as long as they experience their lives as having meaning and value and they have something to live for. He proposed people destroy themselves (through active or passive suicide) in response to an invitation originating in others they stop living. Thus the ability to listen to patients in order to receive accurate cues to their needs carries wide implications for all health care workers and has been addressed by many (Hochbaum, 1976; Hyman, 1972; Kinlein, 1977; Leiber, Plumb, Gerstenzang, & Holland, 1976; Parsons, 1977; Roberts, 1976; Rosenbaum, 1975).

When a person must be continually on guard lest some potentially damaging information is revealed, spontaneity and disclosure are not possible and communication is hindered. A study by Pienschke (1973) demonstrated what happened on a nursing unit when patients either knew, or did not know, their diagnosis and prognosis. Patients who had knowledge of their diagnosis and prognosis were found to be more satisfied with information given them, and with the nursing care they received. It was also

found the approach, either guarded or open as it concerned diagnosis and prognosis influenced the degree to which nurses recognized and attended the patients' needs.

That comprehensive care which includes attention to the patient's psychosocial needs, after the initial diagnosis and plan of treatment have been decided upon, improves both the quantity and quality of survival time was demonstrated by Izsak, Engle, and Medalie (1973). They found in a five year study of cancer patients that when such care was instituted only 3 of the 345 patients in their study required specialized psychiatric help. They further concluded these patients lived longer and apparently fuller lives than patients with similar conditions, as reported by Linden (1969), and Lipworth, Bennett, and Parker (1972). Others (Hyman, 1972; Myers, 1977; Ryzewski, 1977) have also reported that care which includes attention to a person's psychosocial needs has positive health results for stroke patients, diabetic patients, and peripheral vascular disease patients.

Compendium

It has been suggested that cure of illness frequently takes precedence over care. However, in the area of chronic disease, care has been demonstrated to be a factor

in how well patients are able to cope with illness. Comprehensive care appears to improve not only the quantity but also the quality of the patients' lives. Several studies have shown physicians and nurses, as well as the lay public, frequently avoid persons whom they perceive as being incurable, and this may lead chronically ill patients into isolation where their human needs are inadequately met. Communication between health care providers and clients was also explored. It was suggested in several studies that physician and nurse sensitivity to patient communication might be a factor in the way patients cope with illness.

Summary

The literature reviewed for this study covered three areas: the concept of self-disclosure, some personality traits in chronic disease patients, and the impact of the health-care system on those who have a chronic, potentially debilitating disease. The literature reviewed for the concept of self-disclosure showed it can be examined both from a personality and an interpersonal, or communication, construct. Disclosure has been demonstrated to be a factor in mental flexibility and adjustment, and thus possibly in adjustment to physical disease.

It has been suggested if disclosure techniques are taught to and fostered by health care professionals, this may positively influence these practitioners' approaches in guiding clients who seek their services into more healthful living patterns, even when cure of disease may not be possible.

Some of the psychological correlates of several types of chronic physical disease were examined. Anxiety, denial, and depression were common correlates found in all such conditions. So, too, were degrees of social isolation which further compounds the readjustment chronic disease patients must attempt to make if their lives are to continue to have meaning.

The impact of the health care system on those who suffer chronic, potentially debilitating physical conditions was examined. Studies and writings of physicians, nurses, sociologists, and laymen support the view that in today's health system cure is emphasized to a greater extent than care. However, health care providers who are able to communicate care to their patients are felt to add significantly to the aspect of cure.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The methodology employed to compare the self-disclosure levels of adult, nonhospitalized cancer and other chronic disease patients is presented in Chapter 3. The setting, sample population, investigative tools, pilot study, and procedure for the collection and treatment of data are described. This study hypothesized there would be no significant differences in the level of self-disclosure of adult, nonhospitalized cancer patients and adult, nonhospitalized patients who had other chronic, potentially debilitating diseases.

Setting

The setting for this study consisted of a private medical internist's office in a city of approximately 85,000 persons located in the southwestern portion of the United States, and a general medicine out-patient clinic located in a United States Army Hospital. The army post on which the hospital was located was immediately adjacent to the town in which the internist's office was located. At the time of this study the internist was

in an incorporated practice with three other medical internists, but each practitioner maintained his own patient load. The internist saw approximately 350 patients monthly during 1977. He provided medical care to patients who had a variety of acute and chronic diseases. He contracted individually with patients who sought his services as well as accepting patients who might be served by the military hospital and clinics, but who became eligible to seek private civilian care and have the United States Government pay a portion of the fee for services.

The United States Army Hospital in which the general medicine clinic was located had 206 hospital beds. The hospital operated 21 out-patient clinics. In 1977, 306,266 patient visits were made to these clinics. Of this number, 8,004 were made to the general medicine clinic. This clinic served patients who had a variety of acute and chronic conditions. The services rendered were directed toward adults. The patients who were seen in the clinic were referred from physicians in the hospital's other clinics, from the various military unit dispensaries, and personnel transferring from other military posts and commands who were receiving services similar to those offered by this clinic. Persons eligible for care through this

clinic were active duty and retired military personnel and their dependents, as well as the dependents of deceased military personnel.

Population

The 132 patients who comprised the original sample of this study were all older than 18 years of age. None of the patients were hospitalized at the time they were asked to participate and the consent forms were mailed to them. All had a diagnosis of a chronic disease which required they be treated and/or evaluated by the physician at least twice yearly for the same diagnosed condition. Each was being treated for one or more of the following disease categories: cardiovascular disorders, endocrine disorders, respiratory disorders, renal disorders, arthritis, gastrointestinal disorders, systemic lupus erythematosus (SLE) Hansen's disease, or cancer. The sample population was chosen by a method of convenience. All patients identified by the medical internist and all who the head nurse of the general medicine out-patient clinic identified had their records screened for inclusion into the study.

The 61 patients who had a diagnosis of cancer were assigned to group A. All were being treated with chemotherapy according to the medical protocol relative to the

site of the tumor, or had completed therapy and were being seen at regular intervals for continued evaluation. Eight of this group had a second diagnosed, chronic physical condition. Twenty-eight were male and 33 were female. They ranged in age between 20 and 79 years. Racially, 52 of the sample were Caucasian, 8 were Black, and 1 was of Oriental origin.

The 71 patients who had a diagnosis of a chronic physical condition other than cancer were assigned to group B. The patients in this group ranged in age between 19 and 79 years. Forty-eight were female, and 23 were male. Racially, 59 were Caucasian, 7 were Black, 2 were Mexican American, two were of Oriental origin, and 1 was an American Indian. In group B, 28 of the subjects had a diagnosis of a second, chronic physical condition.

Tools

Because self-disclosure can be defined as the verbal transmission of information about oneself (Derlega & Chaikin, 1977), the data gathering instrument employed in this study was an open-ended questionnaire, Green's, R. (1964) Self-Disclosure Sentence Blank. The open-ended questionnaire has the advantage of using the communication method most akin to verbal communication as far as conveying the meaning of symbols between those who have a

relatively common language is concerned (Cardwell, 1971). The demographic data sheet (Appendix A) which accompanied the self-disclosure instrument was designed to obtain information such as sex, age, race, which has been demonstrated by other studies to have an influence on a subject's level of disclosure (Diamond & Hellkamp, 1969; Jourard, 1971b; Jourard & Lasakow, 1958; Littlefield, 1968). The categories of demographic variables were grouped in order to facilitate data analysis.

After reviewing several tools which had been used in other self-disclosure studies (Jourard, 1971b), the instrument developed by Greene, R. (1964) was used. Greene titled the instrument the Self-Disclosure Sentence Blank (SDSB) and described it as follows:

The SDSB consists of twenty sentence stems which the individual is instructed to complete in a manner which will give the examiner an understanding of important aspects of the subject's life. Each response is scored on a five point scale with the help of scoring instructions and empirically derived scoring examples [with one being the most disclosing and five the least disclosing, and with any unanswered stem being scored as a five]. The self-disclosure index for a person is the sum of the scores assigned to his twenty completions. (Greene, R., 1964, p. 42)

After developing the instrument and its scoring manual, Greene subjected it to three separate tests in order to determine its validity and reliability. It was first administered to 10 male and 10 female college undergraduates

who were given written role-play instructions and asked to complete the SDSB as if they were a revealing person, and a second time as though they were a nonrevealing person. Half the males and half the females completed the SDSB role playing a revealing person first and a nonrevealing person second; while the other half of each group reversed the order, that is, they role played as a non-revealing person first and as a revealing person second. The completed SDSBs were then mixed and scored by an unbiased judge. The results of the analysis of variance indicated the difference between the disclosing and guarded scores yielded an F ratio of 44.96, which was significant beyond the .01 level (Greene, R., 1964, pp. 12-15).

The SDSB was next tested under experimentally produced conditions of moderate and low threat. In the low-threat condition, 17 female undergraduates completed the instrument after being told while their names were required on the SDSB, only the experimenter would see their answers and they were merely helping refine a newly designed psychology test. In the moderate-threat condition, 20 other female undergraduates completed the SDSB. This group, too, was told they were helping refine a new psychology test. However, they were told they must place

their names on the instrument in order to compare the results with other information in their school records; and further many people would see the results, perhaps even some of their psychology instructors. Following the completion of the SDSB, each girl was asked to complete a questionnaire designed to reflect differences in perceived threat. The SDSBs were randomized before scoring. A t test computed between mean SDSB scores for the two groups yielded a t value of 2.83, which was significant at $\angle .01$, two tailed (Greene, R., 1964, pp. 15-20).

A third test was designed to demonstrate the predictive power of the SDSB. The subjects were 30 World War II and Korean War veterans who were receiving therapy as outpatients at a veterans' administration mental health clinic and their four therapists. The patient-subjects completed the SDSB at one of their regularly scheduled clinic visits. The completed instruments were returned to the investigator for scoring without examination by the therapists. Each therapist was asked to force-rank his patients in the study "from 1 . . . to n along the dimensions of their willingness to reveal core aspects of their personal and private lives to you" (Greene, R., 1964, p. 76), and to assign each patient a position on an absolute, 5-point scale of self-disclosure. The patients'

scores were compared with the therapists' ratings by means of the Spearman Rank Correlation and the Pearson Product-Moment Correlation. Greene, R. (1964) stated because of the small number of subjects in each therapist's group, the Spearman Rank Correlation showed only "that there was a positive relationship, as predicted, between SDSB scores and therapist ratings" (Greene, R., 1964, p. 24). However, the Pearson Product-Moment Correlation was significant at the $\alpha .01$ level of confidence using a two tailed test (Greene, R., 1964, pp. 23-24).

The reliability and validity of the SDSB was also supported by Haggerty (1964) in a study which showed a significant relationship existed ($r = .54$, $p < .01$ two tailed) between her subjects' willingness to disclose themselves in a tape-recorded interview and their SDSB scores six weeks after they had completed the instrument (Greene, R., 1964, p. 43). Further, Jourard (1971b) cited a study by Graham which utilized the SDSB in measuring attitudes toward death. In that study the difference between the means of the acceptors and nonacceptors (of their own death) was significant beyond the .001 level.

A footnote in Jourard's (1971b, p. 189) book stated the questionnaire may be used or modified by other researchers without written permission. The following

modifications were made (Appendix B) before the instrument was mailed to the study subjects:

1. The words "For Measuring Self-Disclosure" were eliminated from the title because it was felt this might prejudice the respondents and thus contaminate the results.

2. Adding two more sentences in the paragraph of instructions and closing with the words "thank you." Since the instrument was to be mailed to the subjects more clarification was necessary. The words "thank you" were added as an expression of gratitude for the subjects' willingness to participate.

3. Elimination of the demographic section, because this information was not applicable to this study's subjects.

4. By moving sentence stem three down to become sentence stem eighteen. This was done because sentence stem three refers to sex. Other researchers have noted that topics such as sex, if they come early in a questionnaire, frequently cause the respondents to abandon completing the instrument. Sentence stem four was moved to place nineteen because it is a more neutral stem that followed stem three in the instrument as it was originally designed.

Before the instrument was sent to the study subjects, it was coded in order to determine which questionnaires were answered by the group of patients who had cancer (group A) and the group who had other chronic diseases (group B). The method of coding was:

1. All cancer patients received a copy of the instrument as it appears in Appendix B.
2. Patients who had a respiratory disorder received a copy with typed line 20 followed by a period(.).
3. Patients who had a cardiovascular disorder received a copy with the word "Instructions" followed by a colon(:) and no period at the end of line 20.
4. Patients who had a genitourinary disorder received a copy with the word "Instructions" followed by a colon (:) and a period at the end of typed line 20.
5. Patients with an arthritic disorder received a copy with the sentences "Try to do every sentence. Be sure to make a complete sentence" altered so these two sentences become a compound sentence separated by a semicolon(;).
6. Patients with gastrointestinal disorders received a copy with the same wording as number 5 above, but with a period (.) at the end of line number 20.

7. Patients with an endocrine disorder received a copy with the same wording as number 5, but with a colon (:) after the word "Instructions" and no period at the end of line 20.

8. Patients with SLE and Hansen's Disease received a copy with the same coding as number 7, but with a period (.) at the end of typed line number 20.

Pilot Study

Following acceptance of the study proposal by the thesis committee, a pilot study was undertaken to detect any ambiguity in the demographic data sheet, to establish a time reference for completing the data gathering instruments, and to determine the intended rater's ability to score the self-disclosure instrument. The subjects were five graduate nursing students. A cover letter gave instructions for completing the data sheets and asked each respondent to indicate any ambiguity in the demographic sheet and how long it took to complete both sheets. A stamped, self-addressed envelope was supplied for the return of the instruments. All five completed instruments were returned. No ambiguity was noted by any of the respondents. The time required to complete the instruments varied between 8 and 30 minutes. Each of the five disclosure instruments was scored independently by the

by the study's intended rater and an unbiased judge. The judge was a graduate psychology major with eight years of experience in the field of mental health. In the proposal the intended rater's score of 90% agreement with this judge had been stated as an acceptable level for the intended rater to score the self-disclosure instrument. The inter-rater agreement of the intended rater and the judge was 98.75%. The intended rater then scored all the self-disclosure instruments that were completed by the study subjects.

Data Collection

Permission to conduct the study was initially obtained through the Texas Woman's University Human Research Committee (Appendix C). A copy of that committee's approval, a copy of the proposal, and three copies of agency permission forms were hand delivered to the medical internist who had expressed interest in the study. The physician signed the agency permission forms (Appendix D) and made available the patient files for screening. Initially, it had been proposed the study sample would be all of the cancer and other chronic, physical disease patients of this physician, However, the physician chose to screen his own patients and to make available the files of those

he felt would not be unduly upset by receiving a request to participate in the study.

Because the number of patients identified by the physician met only the minimum number delimited in the study proposal it was evident a second source would be necessary. Therefore, a copy of the proposal along with the Texas Woman's University permission forms and letters, three copies of the agency permission form, and a cover letter were hand delivered to the Chief of Nursing Service at the nearby United States Military Hospital. The request was forwarded to the Surgeon General's Office in Washington, D.C. where permission was granted to conduct the study if the intended hospital's medical and education review board approved. Approval was obtained and the agency forms were signed (Appendix E). A meeting was held with the hospital's inservice director and the head nurse of the general medicine out-patient clinic. The head nurse supplied a list of the names of patients who were seen on a regular basis for the diagnosed conditions which had been specified for the study.

Although four months and one week elapsed between the time of sending the initial cover letters and the consent forms to the first portion of the sample and the second, both portions were treated as one sample. For

both portions of the sample the same time frame (six weeks) was adhered to for inclusion of data into the study. Because the sample received their medical care from two separate agencies it was necessary to make minor adjustments in the cover letters which accompanied the consent forms (Appendix F). The portion of the sample served by the medical internist received cover letters written both by the physician (Appendix G) and the investigator (Appendix H). The portion served by the military clinic received a cover letter (Appendix I) designed to inform them how they came to be included in the sample, but similar in all other respects to the investigator cover letter sent to the first portion of the sample.

All identified patient files were screened to ascertain the patients met the delimitations of the proposal. As this was established, each patient's name and address were hand written on the first two lines of a 3 x 5 inch card. One line was skipped and the next seven lines contained the patient's age, sex, race, primary diagnosis, secondary diagnosis, patient category (group A or B), and whether the consent was returned. No other record was made or maintained on any of the patients. Each patient whose initial data had been recorded on a card was sent a cover letter or letters (Appendices G, H, I appropriate

to where the records were screened), a consent form (Appendix F), and a stamped, self-addressed envelope for the return of the signed and dated consent. As the consent forms were returned, a second cover letter, Appendix J), the demographic data sheet (Appendix A), and an appropriately coded copy of the study instrument (Appendix B) were mailed to the subject along with a stamped, self-addressed envelope for the return of the data sheets. As each research packet was mailed the subject's name and address were cut apart from the card which contained the medical diagnosis and other demographic data. The name and address were destroyed as a further safeguard of the subject's anonymity. One month following the mailing of the consent forms the names and addresses of all who had not returned their consent forms were also destroyed, although the remainder of the card was kept and the information was utilized in the data analysis. As each completed study instrument and demographic data sheet was returned, they were stapled together and given a number. The demographic information, along with the assigned number was transferred to a contingency table to facilitate statistical analysis. None of the completed study instruments was scored until all had been received. This was in keeping with the way Greene, R. (1964, p. 42)

developed the scoring of the instrument for a group of subjects.

It had been predetermined six weeks from each initial mailing of the consent forms would be the deadline for inclusion of data into the study. A total of 132 consent forms was mailed. Eight were returned by the post office as being undeliverable because the subject had moved without leaving a forwarding address, and one was returned by a patient's family because he had died three days before receiving the consent. All nine cards containing information about these patients were removed from the study. In group A, 29 patients returned their consents, and 15 completed the questionnaires. In group B, 33 returned their consents, and 20 completed the questionnaires. One subject in group B failed to return the demographic data sheet along with the completed study instrument, making the responses unusable in the study. One subject in group A returned the instruments after the deadline date for inclusion into the study. A minimum of 15 subjects in each group had been predetermined as acceptable for the study.

Treatment of Data

The Mann-Whitney Test was employed to indicate significant differences in the level of self-disclosure of subjects who had cancer (group A) and those who had other chronic physical diseases (group B). The same test was used to determine significant differences among the two sample groups. The Mann-Whitney Test is a nonparametric test which is appropriate to compare two independent groups drawn from the same population when the sample size is small, when the responses can be put on an ordinal scale, and when little is known about the distribution of the variable (Siegel, 1956).

Summary

The setting of the study and the sample population which was obtained from the patient files of one private medical internist and one out-patient clinic located in a United States Army Hospital was described. Both the private physician and the clinic served the adult, non-hospitalized cancer and other chronic disease patients required for the study. The tool chosen to measure the level of self-disclosure was Greene's R. (1964) Sentence Completion Blank for Measuring Self-Disclosure. Methods used to establish reliability and validity of the tool

were related. The manner in which the tool was altered for the study, and the rationale for the alterations were given. The pilot study which was used to determine the intended rater's ability to score the tool and to provide a time frame for its completion by the study subjects was explained.

The method of data collection was discussed. Fifteen cancer patients (group A) and 20 patients who had a chronic physical disease other than cancer (group B), completed and returned the data-gathering questionnaires. The data obtained were analyzed by the Mann-Whitney Test to determine any significant differences in the level of self-disclosure between the subjects in group A and group B.

CHAPTER 4

ANALYSIS OF DATA

A quantitative-descriptive study was conducted to determine if a difference existed between the level of self-disclosure of adult, nonhospitalized cancer patients and adult, nonhospitalized patients who had other specified chronic physical diseases. Greene's, R. (1964) Self-Disclosure Sentence Blank was the instrument used. The instrument, along with a demographic data sheet, was sent to the study subjects and received from them via mail. The Mann-Whitney Test was applied to the data to determine significant findings. The hypothesis of the study was that patients who have a diagnosis of cancer do not demonstrate a level of self-disclosure that is significantly different from patients who have other chronic, physical and potentially debilitating diseases.

Description of the Sample

The sample of 35 subjects was assigned to group A if they had a diagnosis of cancer or to group B if they had a diagnosis of a chronic physical disease which had previously been identified as criteria for sample selection.

Group A had 15 subjects, and group B had 20. Twenty-six (74.29%) of the sample were female and 9 (25.71%) were male. Twenty-two (62.86%) were Caucasian females, 9 (25.71%) were Caucasian males, 3 (8.57%) were Black females and 1 (2.86%) was a female of Oriental origin. Of the sample, 2 (5.71%) were aged 18 through 24 years of age, 1 (2.86%) was in the 25 through 34 age group, 7 (20%) were aged 35 through 44, 8 (22.86%) were 45 through 54, 11 (31.43%) were 55 through 64 years old, and 6 (17.14%) were 65 years of age or older. In the sample, 10 (28.57%) of the females were 18 through 44 years of age; all of the males were 45 or older.

The employment status of the sample covered the range of responses which the demographic data sheet categorized. Four (11.43%) of the sample reported full-time employment of 35 or more hours per week. Three (8.57%) reported being employed part-time. Fifteen (42.86%) checked their employment as housewives who were not employed outside the home. Twelve (34.28%) were retired, and 1 (2.86%) was unemployed.

Of the sample, 26 (74.28%) were married and 7 (20%) were widowed, both males and females were included in these figures. One woman (2.86%) reported she was divorced and 1 woman (2.86%) reported being single. Of the sample,

12 (34.28%) reported living with their spouse. Eight (22.86%) reported living with their spouse and minor children. Seven (20%) reported living with their spouse and other relatives, such as grown children, grandchildren, parents, etc. Three (8.57%) reported living with relatives, and 5 (14.29%) lived alone. The number of persons living in the home of the respondents on a full-time basis ranged from 1, for the 5 (14.29%) who reported living alone, to 6 (2.86%) who reported 6 people lived in the home. Of the remainder of the sample, 13 (37.13%) reported two people, 11 (31.43%) reported 3, and 5 (14.29%) reported 4 people lived with them.

The length of time the subjects in the sample reported they had been receiving treatment for their diagnosed illness ranged between 6 months and 34 years. Four (26.67%) of the group A subjects and 3 (15%) of the group B subjects reported they had been ill for one year or less. None of the group A subjects reported illness of more than 15 years, 4 (20%) of the group B subjects reported illness of 16 years or more.

The demographic data sheet contained categories for the subjects to indicate any change in contacts with persons outside their immediate households since the onset of illness. Twenty-three (65.71%) reported there had been no

change, 6 (17.14%) reported their contacts had increased, 5 (14.29%) reported their contacts had decreased, and 1 (2.86%) reported not knowing if the contacts had increased or decreased.

Of the 8 chronic disease categories delimited for the study, 7 were represented in the sample. The category not represented was the respiratory diseases. The subjects in the sample assigned to group B were categorized as follows: 2 (10%) had a diagnosis of Hansen's disease or systemic lupus erythematosus; 6 (30%) had an endocrine disorder; 5 (25%) had arthritis, either osteo or rheumatoid; 5 (25%) had a cardiovascular disorder; 1 (5%) had chronic renal failure; and 1 (5%) had a gastrointestinal disorder.

The instrument utilized to obtain a self-disclosure score for each of the subjects was a 20 sentence completion blank. This instrument had a score range from 20 to 100. The lower a subject scored, the more revealing the responses (Greene, R., 1964, p. 42). No subject in group A or B had a disclosure score of 39 or lower, that is, first level response. Seven (46.67%) of the group A subjects and 13 (65%) of the group B subjects had scores between 40 and 59, or second level responses. Six (40%) of the group A subjects and the remaining 7 (35%) group

B subjects had scores between 60 and 79, or third level responses. Two (13.33%) of the group A subjects had scores of 90 or greater, or fourth level responses.

Some of the demographic variables summarized in this section, and which are presented in the data analysis and additional study findings sections, are shown in Table 1 for the subjects in group A. The table shows the sex, age, race, length of illness, and self-disclosure scores. Table 2 gives the same information for the group B subjects, in addition to showing their specific illness categories.

Table 1
Partial Demographic Information
for Patients With Cancer

Self-Disclosure Score	Sex ^a	Age	Race ^b	Length Illness in Months
40	F	35-44	C	18
44	F	35-44	C	84
52	M	65+	C	54
54	F	55-64	B	12
57	M	65+	C	120
58	F	55-64	C	60
58	F	35-44	C	6
61	F	55-64	C	6

Table 1 (continued)

Self-Disclosure Score	Sex ^a	Age	Race ^b	Length Illness in Months
66	M	45-54	C	36
67	F	45-54	B	7
67	F	65+	C	36
68	M	55-64	C	18
73	M	65+	C	30
90	F	55-64	C	60
93	F	65+	C	180

N = 15

^a F = female and M = male^b C = Caucasian and B = Black

Data Analysis Related to
Study Hypothesis

This quantitative-descriptive study was designed to test the hypothesis that patients who have a diagnosis of cancer do not demonstrate a level of self-disclosure that is significantly different from patients who have other specified, chronic physical diseases. Data were obtained on Greene's, R. (1964) Self-Disclosure Sentence Blank and a demographic data sheet.

Table 2

Partial Demographic Information for Patients
With Specified, Chronic Disease

Disclosure Score	Sex ^a	Age	Race ^b	Duration Illness In Months	Diagnosis*
43	F	45-54	C	96	C-V
47	F	35-44	C	84	Endo
47	F	55-64	C	36	SLE/H
49	F	18-24	B	108	Endo
51	F	35-44	O	12	SLE/H
52	M	55-64	C	144	Arth
53	F	65+	C	60	Endo
54	M	45-54	C	96	C-V
55	F	45-54	C	12	Arth
56	F	55-64	C	12	C-V
57	F	35-44	C	216	Arth
58	F	25-34	C	408	C-V
58	M	45-54	C	156	Renal
64	F	35-44	C	96	Arth

∞
∞

Table 2 (continued)

Disclosure Score	Sex ^a	Age	Race ^b	Duration Illness In Months	Diagnosis ^c
65	F	45-54	C	276	Endo
65	F	18-24	C	60	G-I
65	F	55-64	C	96	Endo
65	F	55-64	C	180	C-V
70	M	55-64	C	16	Endo
70	F	45-54	C	312	Arth

N = 20

^a F = female and M = male

^b C = Caucasian, B = Black, O = Oriental

^c C-V = Cardiovascular, Endo = Endocrine, SLE/H - Systemic Lupus Erythematosus, and Hansen's Disease, Arth = Rheumatoid or Osteoarthritis, G-I = Gastrointestinal

In examining for significant differences between and among the sample's group A and group B subjects, the self-disclosure scores obtained on the study instrument were ranked and a t value calculated. Because the number of subjects, 35, was outside the limits of the table for the Mann-Whitney Test a Z value was calculated and a table of normal distribution consulted (Snedecor & Cochran, 1967). No significant difference was found between the levels of self-disclosure of the two patient groups, $t = 226.5$, $z = 1.45$, $P > .05$. Appendix K shows the self-disclosure scores and ranks of the sample.

The subjects' self-disclosure scores in relation to gender were also analyzed for significant difference between the sample's two patient groups. The scores of the 10 females in group A and the 16 females in group B were ranked and the t value calculated. No significant difference was found, $t = 117$, $T > .05$ two tailed. When the scores for the 5 males in group A were ranked with the 4 males in group B, no significant difference was found, $t = 17.5$, $T > .05$ two tailed.

Because no significant difference was demonstrated between the self-disclosure scores of the sample's group A and group B subjects, nor between their disclosure scores when the variable of gender was applied, the

hypothesis that there would be no significant difference between the level of self-disclosure of the adult, non-hospitalized patients who had a diagnosis of cancer and patients who had specified chronic physical diseases other than cancer was not rejected.

Additional Study Findings

Several findings from the analysis of data appeared relevant to the study purpose of establishing an index of self-disclosure among the group of patients who had cancer and the group who had other specified chronic physical diseases. The subject's ages in relation to self-disclosure was one of the variables examined. Although the sample ranged in age between 24 and 65 years and older, none of the males was younger than 45. Also, all of the group A subjects were 35 years of age and older. In group A, a comparison of the self-disclosure scores for subjects 35 through 44 was made to subjects who were 65 and older. No significant difference was found, $t = 8$, $T > .05$ two tailed. In group B, the self-disclosure scores of subjects aged 18 through 24 years were compared to those of subjects aged 55 through 64 years. No significant difference was found, $t = 14$, $T > .05$ two tailed. When the sample's 35 through 44 year old subjects' disclosure

scores were compared to those who were 65 and older no significant difference was found, $t = 27$, $T > .05$ two tailed.

Race was another variable analyzed in relation to the sample's self-disclosure scores. Group A had 13 Caucasian and 2 non-Caucasian subjects. When these subjects' disclosure scores were ranked no significant difference was found, $t = 14.5$, $T > .05$ two tailed. Group B had 18 Caucasian and 2 non-Caucasian subjects. When this group's disclosure scores were ranked no significant difference was found, $t = 9$, $T > .05$ two tailed.

The mean self-disclosure scores for both the males and the females in group A was 63.2, or third level responses on the study instrument utilized. In group B the mean self-disclosure score for the females was 56.86. For the males in group B the mean score was 58.5. The mean scores for the females and males in group B were classified as second level responses. Although group A had 5 males and 10 females, and group B had 4 males and 16 females, when the self-disclosure scores of each group was categorized according to sex and ranked, the t value was 38 for both. In neither group was this a significant finding, $T > .05$ two tailed. In using gender to examine for significant difference in the level of

self-disclosure for the sample none was found, $t = 141.81$, $z = .7608$, $P > .05$.

The outside-of-household contacts for the sample was examined to determine if a significant difference existed between the self-disclosure scores of patients who reported an increase of contacts as compared to those who reported a decrease. For the sample, two males and four females reported an increase in their number of contacts, and two males and three females reported a decrease. The subjects' self-disclosure scores were categorized, ranked, and a t value calculated. No significant difference was found, $t = 22.5$, $T > .05$ two tailed.

Other study findings which were not statistically analyzed concerned subject participation. While slightly more than half (56.45%) of the subjects who returned the signed consent forms completed and returned the study questionnaires, a proportionately larger number of females appeared to be in the sample than males. Three females were represented for every male who was represented. In the identified study population, from which the sample was obtained, as well as in the return of consents to participate, the male-female ratio had been approximately one male to each female in group A, and one male to every two females in group B. Also, among the group B portion

of the sample no subjects with a diagnosis of a respiratory disorder returned the study questionnaires.

Summary of Findings

In this study of 35 patients who had specified chronic physical illnesses, nonsignificant differences were found between the sample's group A and group B subjects in their self-disclosure scores, and in relation to their disclosure scores and gender. Therefore, the study hypothesis that adult, nonhospitalized patients who have a diagnosis of cancer do not demonstrate a level of self-disclosure that is significantly different from adult, nonhospitalized patients who have other specified chronic physical diseases was not rejected.

Nonsignificant differences were also found between and among the sample's self-disclosure scores in relation to the variables of age, race, gender, and outside-of-household contacts. Other study findings were that the females in the sample outnumbered the males three to one. Approximately 50% of the subjects who returned their consent forms completed and returned the questionnaires.

Summary

This study tested the hypothesis that adult, nonhospitalized patients who have a diagnosis of cancer do

not demonstrate a level of self-disclosure that is significantly different from adult, nonhospitalized patients who have other specified chronic physical diseases. The study sample was 35 patients. The 15 subjects who had a diagnosis of cancer were assigned to group A. The 20 who had one of seven chronic diseases other than cancer were assigned to group B. Data from the subjects were obtained on Greene's, R. (1964) Self-Disclosure Sentence Blank and a demographic data sheet. The Mann-Whitney Test was applied to the data to analyze for significant difference between and among the two patient groups. No significant difference was found and the null hypothesis was not rejected.

CHAPTER 5

SUMMARY, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

This quantitative-descriptive study examined Jourard's (1964) concept of self-disclosure as it pertained to adult, nonhospitalized persons who had cancer and other specified chronic physical diseases. The hypothesis of the study was that patients who have a diagnosis of cancer do not demonstrate a level of self-disclosure that is significantly different from patients who have a diagnosis of other chronic and potentially debilitating diseases. The study sample was drawn from the patient files of a private medical internist and a general medicine out-patient clinic located in a United States Army Hospital. The physician's office and the clinic were located in the same geographical area.

A method of convenience was used in choosing the sample. All patient files identified by the private medical internist and the head nurse at the clinic were screened to determine if the patients met the criteria for sample selection. The sample contained 35 males and females who ranged in age between 18 and 65 years of age

and older. All were being seen by their respective physicians at least once each 6 months for treatment and/or reevaluation of their diagnosed physical conditions. Although the majority of the sample was Caucasian, Blacks and persons of Oriental descent comprised a small portion.

The instrument used in the study was Greene's (1964) Self-Disclosure Sentence Completion Blank. A personal data sheet accompanied the instrument. The study subjects received and returned the letters concerning the study, the consent forms, and the study questionnaires via mail. The study subjects were assigned to Group A if they had a diagnosis of cancer, or to Group B if they had 1 of 7 chronic physical diseases other than cancer which had been specified for the study. Fifty-six Group A subjects were sent letters briefly describing the study and consent forms to sign if they might be willing to participate. Twenty-nine signed and returned their consents and 15 completed and returned the study questionnaires. Sixty-seven Group B patients were sent letters and consent forms. Thirty-three signed and returned their consents and 20 completed and returned the questionnaires.

Data obtained from scoring the instrument were analyzed by the Mann-Whitney Test. Nonsignificant differences were found between the sample's Group A and

Group B subjects in their self-disclosure scores, as well as in relation to their disclosure scores and gender. Therefore, the study hypothesis that adult, nonhospitalized patients who have a diagnosis of cancer do not demonstrate a level of self-disclosure that is significantly different from adult, nonhospitalized patients who have other specified chronic physical disease was not rejected.

Discussion of Findings

The nonsignificant findings of the study might have been related to several factors. The use of only one study instrument may have decreased the chance for determining validity of the findings. A disproportion of males to females, Caucasians to non-Caucasians, and in the age categories of the subjects may have meant the sample was not typical of patients who have a diagnosis of cancer and other specified diseases.

However, the idea that cancer patients are different than other chronic illness patients regarding self-disclosure may not be supportable. A review of research studies (Berglund, 1976; LeShan, 1966; Myer, 1977; Proffit, 1974; Singer, 1973; Thomas & Durszynski, 1974; Vignos et al., 1972) and literature (Goffman, 1963; Headley, 1979;

Jourard, 1971a; Selye, 1976; Strauss, 1975) seemed to suggest that people who have chronic physical illness, no matter what its nature, have certain psychological variables in common, use similar defense mechanisms, and face many of the same difficulties in coping with their disease processes.

It was observed the number of study questionnaires returned was less than what might have been expected in relation to the number of consents returned. Self-disclosure has been defined as being a verbal interaction between two people (Cozby, 1973; Derlega & Chaikin, 1977; Goodstein & Reinecker, 1974). It has been suggested people disclose to those whom they trust (Altman, 1973; Jourard, 1964, 1971a, 1971b; Jourard & Friedman, 1970; Rubin, 1975), while they are still relative strangers to one another (Altman, 1973; Derlega, Wilson, & Chaikin, 1976; Rubin, 1975), and to those whom they perceive as having some degree of power over them (Johnson, 1977; Proffit, 1974; Slobin et al., 1968). Thus, it might be that the lack of face-to-face, verbal contact between the subjects and the investigator decreased the questionnaire response rate, which may have had an effect on the findings.

Conclusions

Because of the nonsignificant findings of the study, the conclusion was that adult, nonhospitalized patients who have a diagnosis of cancer are not significantly different in relation to self-disclosure than adult, nonhospitalized patients who have other specified chronic illness.

Implications

While the findings of this study were nonsignificant, much of the related literature seemed to support the thesis that a relatively large number of persons working in the health care system are often unresponsive to patients' emotional needs, and frequently seem to have a greater concern for cure rather than care of illness (Brown, 1966; Craytor et al., 1978; Duff & Hollingshead, 1968; Feldman, 1974; Fiefel, 1971; Hoover, 1975; Krant, 1976; Parsons, 1977; Strauss, 1975; Schnaper, 1977). Therefore, knowledge of self-disclosure among persons who have physical illness would seem to have pertinence for health care professionals. However, the dearth of reported data available concerning self-disclosure among persons who have known physical illness, and the non-significant findings of this study demonstrate that norms

of self-disclosure are not yet available to those who might use the concept in a holistic approach to patient care.

Recommendations

In this study of the levels of self-disclosure between and among adult, nonhospitalized persons who had a diagnosis of cancer and other specified chronic physical illness, the null hypothesis was not rejected. Because only one study instrument was used, therefore, possibly not accounting for intervening psychological variables that may have had an influence on the subjects' responses to the instrument, it is recommended the study be repeated using a second instrument for internal validity of the findings. Spielberger's (1966) State-Trait Anxiety Inventory, or the neuroticism (N) scale of the Maudsley Personality Inventory (Kissen, Brown, & Kissen, 1969) might be appropriate.

Repeating the study in an area where a large patient population is available is also recommended. The availability of a large patient population might produce a sample of cancer and other chronically ill subjects whose demographic variables are more equally balanced. A sample with more equally balanced variables might increase the

possibility of demonstrating or refuting the conclusion of this study that patients who have cancer are no different in relation to self-disclosure than patients who have other chronic physical illness.

While the literature of self-disclosure reviewed for this study contained some contradictions concerning the kind and amount of disclosure people give, all the study methods described included some verbal, face-to-face contact between the subjects and the investigators. Therefore, it is recommended any repeat of this study also include the variable of interpersonal subject-investigator contact.

APPENDIX A

INDIVIDUAL DATA SHEET

Please answer the following questions by placing an X in the boxes ☐ below that describe you.

1. Sex: ☐ Male ☐ Female 2. Age: 18-24 ☐ 25-34 ☐ 35-44 ☐
45-54 ☐ 55-64 ☐ 65 & older ☐
3. Marital Status:
☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Single (never married)
4. Race: ☐ Caucasian (White) ☐ Afro-American (Black) ☐ American Indian
☐ Spanish-surnamed (Mexican-American, Chicano, etc.) ☐ Other (specify) _____
5. Employment: Full-time means 35 or more hours/week; part-time means less than 35 hours per week.
☐ Full-time employed ☐ Unemployed at the present time
☐ Part-time employed ☐ Housewife who does not work outside
☐ Retired of own home
6. With whom do you live?
☐ Spouse (husband or wife) only
☐ Spouse (husband or wife) and minor children
☐ Spouse (husband or wife) and other relatives--parents, grown children, grandchildren, etc.
☐ Relatives ☐ By myself ☐ Friend(s)
7. How many people live in your household on a permanent basis?
☐ 1 (myself only) ☐ 4
☐ 2 ☐ 5
☐ 3 ☐ 6 or more
8. Since you have been seeing your doctor for your present health problem, do you see friends and relatives who do not live with you:
☐ More often
☐ Less often
☐ No change
☐ I don't know
9. How long have you been under treatment for your present health problem? _____

APPENDIX B

GREENE'S (1964) SENTENCE COMPLETION BLANK

Instructions

This sentence completion blank is designed to help gain an understanding of your basic feelings concerning yourself and your personal world. Please complete these sentences to express your real feelings, trying to be as frank as possible about matters which are personally important to you. This is not a test so spelling and grammar are not important. Also you may take as much time as you need to answer the questions (most people do them in about 30 minutes), but your first response is probably the one that you really feel. Please feel free to write any comments you have about any of the questions on the back of this paper. Thank you.

Try to do every sentence. Be sure to make a complete sentence.

1. Sometimes I _____
2. I can't _____
3. There have been times when _____
4. My biggest problem is _____
5. I secretly _____
6. I feel _____
7. Loneliness _____
8. I feel guilty _____
9. I have an emotional need to _____
10. I regret _____
11. I hate _____
12. I am afraid _____
13. I _____
14. I am best when _____
15. I am worst when _____
16. I need _____
17. I punish myself _____
18. Sexual thoughts _____
19. I often wish _____
20. I am hurt when _____

APPENDIX C

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TEXAS WOMAN'S UNIVERSITY

Human Research Committee

Name of Investigator: Beverly A. Burnett Center: Dallas
Address: 1605 Lake Date: June 19, 1978
Lawton,
Oklahoma 73501

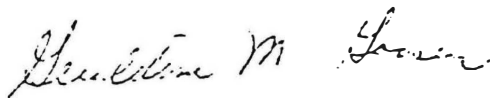
Dear Ms. Burnett:

Your study entitled The level of Self-Disclosure of Adult Nonhospitalized Cancer and other Chronically Ill Patients has been reviewed by a committee of the Human Research Review Committee and it appears to meet our requirements in regard to protection of the individual's rights.

Please be reminded that both the University and the Department of Health, Education and Welfare regulations require that written consents must be obtained from all human subjects in your studies. These forms must be kept on file by you.

Furthermore, should your project change, another review by the Committee is required, according to DHEW regulations.

Sincerely,



Chairman, Human Research
Review Committee
at Dallas

APPENDIX D

HOUSTON CENTER
1130 M.D. Anderson Blvd.
Houston, Texas 77025

THE

The Level of Self-Disclosure of Adult Nonhospitalized Cancer and
Other Chronically Ill Patients

1. The agency ~~is~~ (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency ~~is~~ (may not) be identified in the final report.
3. The agency (wants) ~~to have a~~ conference with the student when the report is completed.
4. The agency is (willing) ~~to~~ to allow the completed report to be circulated through interlibrary loan.
5. Other: *W. T. Jones - 46 Jones - 46 Jones - 46 Jones*

Date _____

Signature of student

Signature of Agency Personnel

Signature of Faculty Advisor

*Fill out and sign three copies to be distributed as follows: Original - Student; first copy - agency; second copy - T.W.U. College of Nursing.

APPENDIX E

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS

DALLAS CENTER
1810 Inwood Road
Dallas, Texas 75235

HOUSTON CENTER
1130 M.D. Anderson Blvd.
Houston, Texas 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Reynolds Army Hospital

GRANTS TO Beverly A. Burnett

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

The Level of Self-Disclosure of Adult Nonhospitalized Cancer and Other Chronically Ill Patients

The conditions mutually agreed upon are as follows:

1. The agency (may) (~~must~~) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (~~must~~) be identified in the final report.
3. The agency (wants) (~~must~~) a conference with the student when the report is completed.
4. The agency is (willing) (~~must~~) to allow the completed report to be circulated through interlibrary loan.
5. Other: _____

Date 7 September 1972

Beverly A. Burnett
Signature of student

Col. Smith 15 SEP 72
Signature of Agency Personnel
ROBERTA N. CAROL
Signature of Faculty Advisor

*Fill out and sign three copies to be distributed as follows: Original Student; first copy - agency; second copy - T.W.U. College of Nursing.

APPENDIX F

Consent To Act As A Subject For A Research Study

The following information is to be read by the person agreeing to participate:

1. I hereby authorize Severly A. Burnett, a graduate student at Texas Woman's University to send me two sheets of paper that contain questions I can fill out in my own home.
2. Mrs. Burnett included a letter with this consent form explaining the study.
3. I understand that answering some of the questions may cause me to feel self-conscious.
4. By answering the questions I may get a better understanding of myself and be able to give nurses a better understanding of people who have health problems similar to mine.
5. Mrs. Burnett has offered to answer any questions about the study that I might have. I understand that I may stop my participation in the study at any time.

Subject's signature

Date

APPENDIX G

~~CONFIDENTIAL INFORMATION, ETC.~~
~~THIS COPY MUST BE DESTROYED~~
~~DATE: 10/10/80 BY: [REDACTED]~~

[REDACTED]

[REDACTED]

July, 26, 1978

Dear

This letter is to introduce Mrs. Beverly Burnett, a nurse doing a special study on the feelings of patients who have certain illnesses. As a part of the study Mrs. Burnett would like to send you two questionnaires which you can fill out at home. The answers will be kept in confidence, and I do not plan to review the answers--just the final result. I believe we as physicians must try to deal with the feelings that our patients have in addition to their medical problems. Included with this letter is one from Mrs. Burnett, along with a form for you to sign if you will assist her in this study.

Thanks very much for your cooperation.

Sincerely yours,

[REDACTED]

APPENDIX H

Dear

In his letter Dr. ██████ told you a little about me and the study I am doing. I am a graduate student at Texas Woman's University and the study is part of the requirements for my masters degree in nursing. As a nurse I believe that a better understanding of the feelings of people who have a health problem will help doctors and nurses to be more sensitive to the needs of all patients. By participating in the study you may learn more about your feelings and also assist those of us in the health-care professions in providing better service to our patients.

With your permission I would like to send you two sheets of paper containing questions which you can fill out in your own home. Your decision to fill out these questionnaires is voluntary and will not affect your relationship with Dr. Leckman in any way.

Although I will need your consent before I can send you the study questions I can guarantee you that because no identifying letters or numbers will be on them, and you would receive them several days after I have received your consent back from you, no one can match you personally with anything you write on the sheets. Also I will not use your name or identify you in any way in the study; nor will I make any effort to contact you by phone or in person.

If you will assist in this study, please read and sign the enclosed consent form. A stamped, self-addressed envelope has been provided for you to return it to me. After I receive your consent I will send you an envelope containing the questions. It takes most people about 30 minutes to answer them.

Thank you for taking time to read these letters. I hope you will decide to assist in this study by allowing me to send you the questionnaires.

Sincerely yours,

A handwritten signature in cursive script, appearing to read "Beverly A. Burnett, R.N.", written in dark ink.

Beverly A. Burnett, R.N.

APPENDIX I

December, 1978

Dear

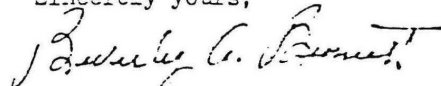
Nurses are interested in helping people to improve their health. They are becoming increasingly interested in finding ways that they can help people who have health problems but who are not in the hospital. One way to do this is to conduct a study. My name is Beverly Burnett. I am a registered nurse (RN) working on a masters degree at Texas Woman's University. Dr. Firk, the medical officer in charge of Reynolds Army Hospital, has given permission for me to send letters to some of the patients who are seen at the General Medicine out-patient clinic. This letter is an invitation for you to participate in this study. By participating in the study you will learn more about your own feelings and also help those of us in the health-care professions to have a better knowledge of people who have health problems.

The study has been set up so that after I receive your consent I will send you two sheets of paper that contain questions you can fill out in your own home. Your decision to participate is voluntary and will not affect the services you receive at Reynolds Army Hospital. If you choose to take part I will need your written consent, but I can guarantee that your name will not be used in any way in the study, and that no one will be able to recognize you by your answers on the questionnaire sheets.

If you will take part in the study, please read and sign the enclosed consent form. A stamped, self-addressed envelope has been provided for you to return it to me. After I receive your consent form I will send you an envelope that contains the questions. It takes most people about 30 minutes to answer them.

Thank you for taking time to read this letter. I hope you will decide to assist in the study by allowing me to send you the questionnaire sheets.

Sincerely yours,



Beverly A. Burnett, R.N.

APPENDIX J


Dear

Thank you for your consent to assist me in this study. Enclosed you will find two sheets of paper. One is called an Individual Data Sheet, the other is titled Greene's (1964) Sentence Completion Blank. The instructions for filling out these papers are printed at the top of each one. There is also a stamped, self-addressed envelope for you to return them to me. In order to guarantee that I will not be able to identify you, please do not sign your name to either of the sheets. Because your name will not be on the sheets, and no identifying letters or numbers are on them or the envelope, there is no way that I will be able to identify you with what you write. This is not a test so please do not be concerned about your spelling or grammar.

If you are interested in receiving a copy of the early findings of the study you may write me after _____ and I will be glad to forward this to you. However, because I will not be able to identify your answers from those of the other people who are also assisting in the study, I will not be able to tell you how your answers compared to theirs. If you care to see the completed study it will be available in the Cameron University Library after August, 1979. It will be listed under my name.

Again I wish to thank you for assisting me in this study.

Sincerely yours,


(Mrs.) Beverly A. Burnett, R.N.

APPENDIX K

SELF-DISCLOSURE SCORES AND RANKS OF PATIENTS WITH
CANCER AND OTHER SPECIFIED CHRONIC DISEASES

Group A Scores	Rank	Group B Scores	Rank	Group A Scores	Rank	Group B Scores	Rank
40	1.0	43	2.0	67	28.5	57	15.5
44	3.0	47	4.5	68	30.0	58	18.5
52	8.5	47	4.5	73	33.0	58	18.5
54	11.5	49	6.0	90	34.0	64	22.0
57	15.5	51	7.0	93	35.0	65	24.5
58	18.5	52	8.5	--	--	65	24.5
58	18.5	53	10.0	--	--	65	24.5
61	21.0	54	11.5	--	--	65	24.5
66	27.0	55	13.0	--	--	70	31.5
67	28.5	56	14.0	--	--	70	31.5
				$N_1 = 15$		$N_2 = 20$	

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