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Self-abasement as it Relates to Cancers in Men and Women

by

MARION J. ELLIS
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[redacted]

Dr. D.W. Knowles, Supervisor
(Chair, Department of Psychological Foundations)

[redacted]

Dr. A.A. Oberg, Outside Member
(Department of Communication & Social Foundations)

[redacted]

Dr. R.V. Ferguson, Outside Member
(School of Child and Youth Care)

[redacted]

Dr. J. Newman, External Examiner
(Counselling Services, University of Victoria)

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Supervisor: Dr. Don W. Knowles

Abstract

The relationship between the personality trait of self-abasement and cancer was systematically investigated. This relationship was initially observed in my clinical practice with male and female adult clients with cancer. The main trait behaviour was characterized by constant downgrading of self; even to the extent of sabotaging their preferences in order to avoid hostility.

Studies by Grossarth-Maticek, Kanizir, Schmidt and Vetter (1985) of healthy people showed common characteristics which have a predictive power for cancer incidence. They called for re-evaluation of the role of psychosocial risk factors in the etiology of cancer.

My research tested the hypothesis that the disease of cancer was associated with the trait of abasement in women and men. Since norming data for the demographic group was not available prior to this research, an initial hypothesis was that, within a healthy group, women would show a higher level of abasement than men. Further, it was hypothesized that the abasement trait had levels which were different for people with cancer as opposed to people without cancer. The effect of abasement would be dependent on all three: sex, age, and cancer. I posited that the traits of dominance and need-for-approval were independent of sex, age, and cancer.

The following research question was investigated:

> Are there any mean scores for abasement, need-for-approval, or dominance that were different in non-cancer as compared to cancer patients?

A total of 82 male and female adult voluntary participants, referred by their family medical doctors, were selected from two groups: medically diagnosed with cancer and no-cancer. Age range (40 to 85 years) was subdivided into 65

or younger and older than 65. Control and cancer subjects were matched for age and sex. Volunteers completed an adaptation of Jackson's Personality Research Form-E and Marlowe-Crowne's social desirability scale.

MANOVA found a significant interaction for abasement across age by sex by cancer state, F = 5.487, p. <.05. There were main effects on dominance for both sex, F = 10.719, p. <.05, and age, F = 8.090, p. <.05. Adapted Marlowe-Crowne scores for need-for-approval are dependent on age and cancer state, F = 5.064, p. <.05, with a main effect of sex on need-for-approval, F = 5.725, p. <.05.

This research supports the need for further studies in health psychology regarding psychosocial risk factors with attention to generalizability of patterns of self-abasement and their relationship to cancer state.

[redacted]

Dr. D.W. Knowles, Supervisor
(Chair of Department of Psychological Foundations)

[redacted]

Dr. A.A. Oberg, Outside Member
(Department of Communication & Social Foundations)

[redacted]

Dr. R.V. Ferguson, Outside Member
(School of Child and Youth Care)

[redacted]

Dr. J. Newman, External Examiner
(Counselling Services, University of Victoria)

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Chapter One

Introduction

Personality was reintroduced in the first half of this century as having a relationship with disturbances in the body and illnesses. This change in perspective once again united the relationship of the mind and the body, in the eyes of the scientific community, as one system rather than two separate ones. In the middle of this century, psychosomatic medicine emerged with the view that bodily illnesses were caused by inner emotional conflicts resulting in anxiety which created changes in the body (Engel, 1986). In this decade, researchers have proposed that personality patterns alone are not sufficient to cause disease, but rather that multifactorial interactions are responsible for the onset of illnesses (Taylor, 1991). Taylor suggested that these factors include genetic weaknesses, external stressors, coping efforts, cognitions and internal conflicts from early and ongoing experiences, all of which, as shown by Levy (1985), have been interrelated with personality in the literature. Therefore, personality characteristics, as variables, are important to research as it seems likely that they interact to influence disease (Levy, 1985).

In the present study, the relationship between the personality trait of self-abasement and the condition of cancer was systematically examined to test clinical data

arising from my therapy practice with adults diagnosed with cancer. I hoped that the results from this research would contribute to the understanding of personality and disease and that ideas for appropriate interventions would emerge for health practitioners to utilize.

Clarification of Terms

Three personality traits--abasement, need-for-approval, and dominance--appeared to have particular relevance to my observations from my clinical practice with men and women diagnosed with cancer.

Abasement is evidenced by avoidance of conflict, despite the consequences to one's self-image, which culminates in self-effacement. Need-for-approval relates to abasement in that avoidance of conflict is a common factor; however, need-for-approval is a trait that arises from a need to respond in a socially desirable manner. Dominance as a personality trait illustrates the assumption of leadership in social interactions, evidenced positively by influential direction or negatively by forceful control. For research purposes, the traits of abasement, need-for-approval, and dominance have not been defined in the most extreme manner but rather have been defined in such a way that they reflect a high score obtained in a research participant's questionnaire. Nevertheless, as a therapist, I sense even greater levels of abasement, and need-

for-approval, along with avoidance of dominance in the lives of men and women diagnosed with cancer.

The first personality trait to be discussed is abasement. In everyday conversation, abasement is rarely thought of self-referentially. The word abasement is usually understood to be a dominating action which lowers the dignity and value of another person. People tend to think in terms of the dominator, also referred to as the abaser, when in actuality abasement concerns passive acceptance, self-denial and self-effacement as well. The purpose of this study is to direct our attention to the self-referential aspects of abasement, herein called self-abasement, particularly as these aspects relate to adults with cancer.

I formulated my clinical definition of self-abasement over a period of ten years in my clinical therapy practice with one hundred and ten adults with cancer. I consistently observed, in these clients, a characteristic of pleasing others at all costs. When explored further, this trait is revealed to be part of a complex pattern of behaviour. While the research is not conclusive, this study is an initial step in the consideration of this complex pattern as an archetypal trait of people with cancer. The main characteristic of this behaviour is the tendency to downgrade the self constantly, even to the extent of sabotaging one's own preferences. This is done in an effort to please in order to gain approval and to avoid tension or confrontation. The result is an ironical

self-satisfaction: by downgrading the self, the individual feels safe. The most important aspect of this clinical observation of self-abasement is the great extent to which these behaviours occur in these peoples' lives.

Henry Murray (1938), a medical doctor and Assistant Professor in psychology at the Harvard Psychological Clinic, first identified abasement as a "sub-need, but because of its general importance it [was] given a separate status" as a personality trait (p. 162). Murray defined abasement as submitting passively to external force and accepting physical injury without retaliation. Furthermore, to be abasing was to be accepting of blame, criticism and punishment, and turning these effects into a belittling of the self resulting in self-mutilation. He described the feelings and emotions that relate to abasement as mutilation, resignation, shame, guilt, helplessness or despair, and inferiority or humility. Murray's full descriptors of abasement are reported in Appendix C.

Murray's discussion of certain descriptors of abasement reflects meanings poignantly similar to my clinical observations of abasement experiences. Murray referred to self-mutilation as affecting both the physical and emotional aspects of a person: self-mutilation was related to masochism. Nevertheless, while masochism is currently differentiated as pathological, abasement is considered a normal personality trait. When abasement is linked with masochism it would seem that pain, illness, or punishment is sought and enjoyed.

Murray differentiated between seeking pain and avoiding further pain or anticipated punishment, which is the goal served by abasement. I have observed that this avoidance behaviour often takes the form of submissiveness.

My clients have not consciously or unconsciously sought these abasive behaviours, nor did they express joy about the self-abased situations in which they found themselves. Instead, clients were motivated by the need to avoid tension or hostility and confrontation. They seemed to experience an unconscious fear of hostility and an awareness of the need for safety. Murray's description of abasement agreed with my observations with a particularly strong connection between abasement defined as submissiveness or passivity motivated by avoidance.

Dr. Douglas Jackson, Professor of Psychology at the University of Western Ontario, has modernized the research of Murray's personality variables. Jackson (1984) claims he has attained "a more rigorous and more valid assessment of important personality characteristics" (p. 4) which are considered to be normal rather than psychopathological. Therefore, abasement is now considered to be a normal personality trait which we all have to some degree. Jackson's operationalized and well-tested definition of abasement was used as the definition for self-abasement in the present research study. In his definition, a highly abased person has four main characteristics:

1. Shows a high degree of humility;

2. Accepts blame and criticism even when not deserved;

3. Willing to accept an inferior position;

4. Tends to be self-effacing (p. 6).

The "defining trait adjectives" which he suggested are:

> meek, self-accusing, self-blaming, obsequious, self-belittling, surrendering, resigned, self-critical, humble, apologizing, subservient, obedient, yielding, deferential, and self-subordinating (p. 6).

Jackson's (1984) operationalized definition, as stated above, represents one pole of a bipolar definition of a high abasement scorer, derived both "theoretically and in terms of measurement" (p. 25).

Jackson's four main characteristics of abasement resemble characteristics noted in my clinical observations. "A high degree of humility," Jackson's first descriptor of abasement, was commonly played out in my clients' lives. Often, prior to their diagnosis of cancer, these adults were repeatedly told, both by their peers and health practitioners, to seek psychological help. However, this recommendation did not motivate them to assert themselves on their own behalf. Clients often said that, "seeking help was very difficult, [they] just could not get [themselves] to call earlier." When exploring their feelings with me, it often became clear that their humble affect arose from a deeper need to avoid humiliation. It is ironic that "a high degree of humility," arises from a need for a self-protective strategy. This is

ironic because my clinical observations suggest that this agreeable and often rewarded behaviour acts as an unconscious defense against humiliation for those with a disease of cancer. My clients' "high degree of humility" coincides with this aspect of Jackson's definition of abasement.

From clinical observations, the desire to avoid blame and criticism was strongly expressed by men and women with cancer. They described themselves as passive or unable to speak out in the face of blame or criticism. In counselling sessions they described themselves as "freezing up and unable to respond," or "going away to some place inside" until the external criticism, either verbal or facial ceased. Due to their lack of response in these threatening situations, they appeared to "accept blame and criticism even when not deserved," which is Jackson's second descriptor of abasement. The realization of their unconscious avoidance of blame only became clear to them with the aid of therapeutic intervention.

Adults with cancer also find themselves "willing to accept an inferior position," which illustrates the third part of Jackson's definition of abasement. I observed clinically that the inability to speak-up for the self, which resulted in accepting inferior positions, led to clients feeling used, which in turn led to "self-accusing" and "self-blaming" thoughts. An example of this series of behaviours, feelings and thoughts in my clients follows:

> I find myself at the end of lines a lot. I don't start out there but people step in front of me and

> I'm willing to just accept that. I cower. I ask myself, 'why am I allowing myself to let this happen? Why don't I stand up for myself?' I come to the conclusion that there must be something wrong with me! I'm a coward, a whimp, I don't have any backbone. I get down on myself thinking that I am pointless and that there is no hope for me.

Clients expressed feelings not only of willingness but resignation to accepting these inferior positions. Their resignation resulted in an enduring and hidden despair, which further increased their passivity and their tendency "to accept an inferior position."

The personality trait of self-abasement is lived out to such extremes by my clients diagnosed with cancer, that I have been wondering how to account for these extremes. If all four aspects of Jackson's definition of abasement, described above, are considered in an additive way, and seen as culminating in self-effacement, then the extent to which this trait is involved in their lives becomes clearer. Therefore, I believe that the next characteristic of abasement to be discussed--self-effacement--is of particular importance.

The fourth and final characteristic that Jackson uses to define abasement is the "[tendency] to be self-effacing," which is also the culminating aspect of abasement. Self-effacement means "to abandon one's claim to consideration," in a figurative sense to obliterate a memory, to obtain pardon for an offence and to abolish or destroy distinctive characteristics (OED). In my clinical experience, self-effacing behaviour on the part of clients was a common

pattern. Their inability to focus on or to feel emotion for example, was very often experienced as a "hazed" mind. The "hazed" mind paralleled sensations of numbness in the body representing suppressed past and present experiences.

For example, a client reported the following self-effacing experience:

> My body has a will of its own when I ignore it . . . I feel like I've lost my body's phone number. I space out, my thinking is hazed or fuzzy, and I lose track of things, like my car, for two hours.

This client's mind was unable to focus and her body did not experience feelings clearly either. It was as if aspects of herself had been obliterated, demonstrating the most severe self-effacing effect that the trait of abasement may have on a person.

When the "self-effacing" aspect of self-abasement emerges in the therapeutic setting, internal conflicts from early experiences begin to surface:

> I remember that I had to not have needs as Mom had a nervous breakdown and went to bed for seven years. I was nine years old and I was the oldest of four. Dad didn't live with us anymore; so, I took care of everyone, including Mom. I realize now that I went into overdrive so that I could just do it. I felt nothing.

This client's early experience of abandonment by both parents, resulted in a "self-effacing" reaction which obliterated her needs and her bodily sensations.

An even more extreme example of self-effacement may be demonstrated in the "splitting off" of mind from body that frequently was an ongoing experience in my clients' lives:

> I hurt my right arm, it's always my right side I hurt. I've had to learn how not to override my signals. I've learned that when my arm hurts, I need to stop what I'm doing . . . Before [therapy] I didn't think about my ankles and wrists, in fact I didn't feel much in my legs from the knees down. What I didn't know, I didn't miss. If someone had asked me "Do you feel your legs?" I would have said, "Yes, of course I do, I have two feet and two legs." As far as I was concerned my body worked fine. Now that I've done some therapy I realize that I could have been going toward death [of the bodily sensations] and not even have known it. Once I realized the amount [extent to which] I wasn't going in the sensation direction which is life, it was scary. Until I felt the gain [of sensing bodily sensations], I wasn't aware of the seriousness of the price of not knowing I couldn't feel my legs.

This client split off from her physical sensations as well as her inner emotions, both of which were reflected in her thought "What I didn't know, I didn't miss." However, the lack of bodily signals endangers the client's physical well-being. The splitting off from protective signals from the body renders the client a victim. This victimization is a result of the fragmenting effects of self-effacement.

Another example of early abandonment and ongoing trauma was experienced by a client who said that:

> My doctor [with whom she had been consulting for eight years] felt that my symptoms went back to my childhood, I wouldn't believe him for years. But you know my Mom died when I was two years old and Dad didn't think he could take care of me so he was going to give me away. The plans were all set. Then he couldn't do it but I realize now that I was so scared. Now I know I've been pleasing him ever since 'cause I didn't want to be given away.

Her pleasing behaviour, although socially desirable, was paradoxically damaging to herself. Eventually she revealed that she had thought, "If I'm good then Dad won't send me

away." By being good she had tried to accomplish two things: she had wanted to win her father's approval and to protect them both from her step-mother's anger. During her childhood, this client did not realize that she had protected her father at an enduring expense to herself. Unconsciously, she tried to protect him by erasing many of her own needs and emotions in an effort to feel safe. However, the ongoing effects created further trauma, as she herself observed:

> I never say no. I never would express my anger . . . I'd never say anything against my step-mother 'cause she'd take it out on Dad. I couldn't allow that. I feel haunted by her [step-mother] . . . I thought she couldn't hurt me anymore. Then I found myself weak like rubber out of fear of running into her in the town where she lives. And I hadn't seen her for years.

For this client, the feeling of being "haunted" represented a fear of her step-mother's anger and her own. The result of this fear of hostility culminated in self-effacement; in that by withdrawing her needs, she had "abandoned her claim to consideration."

Clinically, I have witnessed each of these characteristics of abasement in my adult clients who were diagnosed with cancer. I have observed that humbleness was related to avoidance of humiliation; self-criticism was linked to passivity and the strong need to avoid hostility from others; acceptance of inferior positions was linked to powerlessness, passivity and self-criticism; and self-effacement was likened to a self-obliteration both physically and mentally resulting in a truly powerless victimization.

There is a paradoxical theme inherent in these examples demonstrating the four aspects of self-abasement in that the action of thinking and being positive, for example being humble, may actually have self-sabotaging consequences for the person with cancer. Ostensibly, such behaviours may be respectable, self-protective and harmless; but, upon careful reflection, they may constitute a strong self-effacement and thus indicate an ongoing personality trait of self-abasement.

The second personality trait considered in the present study was need-for-approval which arises from a need to respond in a socially desirable manner. My clients often exhibited an extreme desire to please which appeared to result from their high-need-for-approval; it was this characteristic which initiated my research on self-abasement. Clinically, my clients would respond to me in a manner that "conformed to social stereotypes of what [was] good to acknowledge concerning oneself in order to achieve approval from [me]" (Marlowe & Crowne, 1964, p. 27). Marlowe and Crowne (1964) suggest that people vary in their need to be thought well of by others:

> For those whose need is high, we could assume a generalized expectancy that approval satisfactions are attained by engaging in behaviours which are culturally sanctioned and approved (and by avoiding those responses which are not) (p. 27).

This pattern of behaviour is illustrated in the case of the client (see p. 10 & 11), who as a child, had been traumatized by the fear that her father would "send her away," following

the death of her mother. As a child, it was simply not socially desirable to respond with anxiety, frustration, anger, strange thoughts or impulses. Neither did she feel safe enough as an adult to express these feelings to me in a clinical situation. Marlowe and Crowne found this same behaviour in their test situations and considered it to be consistent if "one [was] dependent upon the acceptance, recognition, and approval of others" (p. 27).

Marlowe and Crowne (1964) carried out a series of extensive studies on the "approval motive," focusing on people who were generally inclined to agree. Their work has brought us a long way from the 1930's, when need-for-approval was seen as an aware and deliberate faking or hiding of oneself. Currently, this behaviour is understood to be an habitually unaware response style protecting one's vulnerable self-concept. Marlowe and Crowne (1964) equated the trait of high-need-for-approval with a "dependence on favourable evaluations of others and a vulnerable self-conception" (p. 195). Marlowe and Crowne made two very important points:

> 1. People unconsciously altered their responses in the test situation and did so because of their ongoing resignation to the necessity of adhering to the factors concerning social desirability as a defense against hostility and criticism. Their behaviour was consistent in both social and

clinical testing situations and was triggered by their perception of external evaluation.

2. In their experiments, Marlowe and Crowne (1964) were able to reproduce the situations which subjects experienced as being painful and stressful due to their high-need-for-approval. These earlier social experiences had created hostile social encounters for these subjects which alienated them from their environment, thereby creating a long-term social and psychological impact on the individual's healthful adaptation to that environment.

Their ineffectual efforts to gain acceptance and to be liked were ironically self-sabotaging--Marlowe and Crowne noted these people were generally disliked. Moreover, these behaviours were anchored to the cultural norms leaving subjects more conforming, cautious and persuasible than low-need-for-approval subjects. Resignation to a high-need-for-approval behaviour pattern lowered their self-esteem while trying to protect it; this behaviour pattern rendered them dependent on the acceptance of others and had a negative long-term effect on their health.

After an extensive review of the literature this researcher proposes that studies should be initiated in the 1990's focusing on comparative research between need-for-approval and self-abasement, especially in relationship to the

disease of cancer. I suggest that the trait of need-for-approval is similar to self-abasement in that both encompass a feeling of resignation or despair. Both Marlowe and Crowne (1964) and Jackson (1984) respectively, consider that those responding as high scorers of need-for-approval and self-abasement are defending against hostility and criticism from others. Clinically I observed that hostile behaviour, whether their own or that of others, is a source of difficulty for people with cancer whether they exhibit a characteristic of need-for-approval or a trait of self-abasement. When working therapeutically with adult men and women with cancer it seems that the trait of need-for-approval is encompassed within or is a subset of the attribute of self-abasement because the two traits seem so similar. Personality research also classifies these two traits as similar or psychologically close together in terms of psychological distance. Moreover, personality research designates need-for-approval and self-abasement as different enough to be two separate traits.

The third and final personality trait to be discussed is domination. Murray (1938) defined dominance as influencing or controlling others to the extent of prohibiting and dictating. For Murray, dominance was also leading, directing and organizing; therefore, it was often related to achievement, autonomy and aggression. At its worst, Murray considered dominance to have an obstructing or coercing effect rather than nurturing.

Jackson (1984) described the high scorer of the dominance trait to be one who:

> 1. Attempts to control environment;
> 2. [Attempts] to influence or direct other people;
> 3. Expresses opinions forcefully;
> 4. Enjoys the role of leader and may assume it spontaneously (p. 6).

He contended that the "defining trait adjectives" were:

> governing, controlling, commanding, domineering, influential, persuasive, forceful, ascendant, leading, directing, dominant, assertive, authoritative, powerful, supervising (p. 6).

According to Jackson, dominance was in theoretical opposition to abasement and even at opposite poles of different dimensions (see Chapter 2 - Concept of Multidimensionality and Disease) but a low scorer of the characteristic of dominance shows submissiveness which relates to abasement.

I have observed clinically that for adults dealing with cancer, domination represents control, coldness, forcefulness, blame, criticism and humiliation. For adults with cancer the dominator is an abuser and for this reason many hours of therapeutic work must occur before fears of external force are expressed. In fact, clients often expressed that for them another person's opinion, stated without obvious force or hostility, seemed like domination. Their acquiesence to the dominant behaviour of others resulted in the self-sabotaging pattern of abasement. In this way dominance is related to abasement, in that when acquiescing to dominant behaviour one is being abased. How my clients with cancer react to domination in everyday life seems to determine whether they

resist it or adopt it. This behaviour constitutes an extreme approach to an extreme personality trait.

Overview of this Research

The present study provides a consideration of the extent to which self-abasement, need-for-approval, and dominance are associated with a diagnosis of cancer in a sample of men and women over forty years of age. To establish norms for comparison, I gathered scores on measures of self-abasement, need-for-approval, and dominance from a healthy group. Both sexes are included as personality research identified all of these traits as normal in both men's and women's lives. I have also observed clinically that abasement levels seem to increase for both sexes with a cancer diagnosis. The older age range of forty to eighty-five years was chosen because it represented the greatest number of subjects available from the offices of family physicians. The matching healthy group was a starting point for establishing norming data. This was necessary because Jackson's (1992) norms for men and women apply only to the age of thirty and under (Interview, University of Western Ontario).

All serious cancers, including melanoma which is the only serious skin cancer, were included in this study. This was done for two reasons. Firstly, my clinical observations of high levels of abasement occurred in my clients with a cross-section of all serious cancers. Secondly, including all

serious cancers in this research allowed for the greatest potential number of volunteers and thus enhanced the matching of the criteria.

The intention of this research was to explore the hypothesis that the disease of cancer was dependent on the trait of abasement in women and in men as well. Since norming data for the demographic group were not available prior to this research, I suggested that the norms from the healthy group would show a higher level of abasement in women than in men. It was my contention that the abasement trait, as specifically defined by Jackson (1984), had levels which were different for people with cancer as opposed to people without cancer. Furthermore, I contended that this difference in abasement levels between cancer and no cancer groups was discernible only when we consider the client's sex and age. The trait of need-for-approval was seen as separate from abasement. From clinical observations, need-for-approval seemed to be similar to or to comprise a subset of abasement. Furthermore, I posited that the trait of dominance was dissimilar from abasement and independent of the disease of cancer. The research question posed asked whether there were any mean scores for self-abasement, need-for-approval or dominance that were different in non-cancer as compared to cancer patients' scores.

If abasement was not the criterion variable, an alternate explanation was that the need-for-approval rating differed

across the cancer and no cancer groups. Therefore, need-for-approval would not be dependent on abasement.

Despite my clinical observations which may imply causation, any inferences about causation deriving from these hypotheses would be extremely suspect. Suspicion would be aroused due to the limiting nature of the sampling technique and its lack of representativeness for the population of all adults diagnosed with cancer.

Predictability beyond the subject sample of the present study was never the intended aim of this research. However, the clinical reports and the systematic exploration of specifically defined variables has made it possible for me to make information about the relationships between sex, age, cancer, and these personality variables available to a variety of health practitioners. The treatment techniques of health practitioners may be impacted by the implications of this study.

Chapter Two

Review of the Related Literature and Theory

The personality trait of self-abasement has not been explored in relationship to the diseases known as cancer; therefore, there was no direct research to review. Consequently, I have taken terminology from other applications of personality, disease, and cancer, and sought to consider them in a new way. My choice of the topics discussed was guided by factors that seemed important to my clients, diagnosed with cancer, as they worked therapeutically on their self-abasement patterning. Therefore, the literature that I reviewed was tangential at best to the topic researched here and is relevant in so far as it explores some possible linkages of the abasement trait in relationship to other concepts.

Psychological variables do appear to affect the body. The personality trait of abasement previously has not been directly linked with disease. Moreover, the traits of abasement, need-for-approval and dominance have not been directly linked with the disease of cancer. For example, if Type A personality affects heart disease, then perhaps the personality trait of abasement relates to the disease of cancer in some way. Within this possible relationship, a body-mind connection must exist even though the specifics of this connection are not explored here. I explored psychological

traits and physical conditions and attempted to relate them in ways not previously explored.

Grossarth-Maticek, Kanazir, Schmidt, and Vetter (1985) conducted an investigative and longitudinal study in which they explored the relationship between psychosocial risk factors and mortality from prospective cases of cancer. Between 1966 and 1976, in a city in Yugoslavia, this multidisciplinary team sampled a group of 1,353 men and women comprised of the eldest members in each household which was studied. Their subjects were of a similar age as the sample in the present study. Seventy-one percent of their group were men, 87% of whom were over 50 years of age. Twenty-eight percent of the subjects were women, 83% of whom were over 50 years of age. In 1972 Grossarth-Maticek et al. replicated their prospective study in Heidelberg, Germany using a random sample of 1,026 subjects. Thanks to the pilot study in Yugoslavia, the Heidelberg study resulted in clearer predictions, the factors of which could be hypothesized as predictors of future cancer mortality. The Heidelberg study recorded more medical data so that a longitudinal analysis and cross-validation could be done on the basis of repeated investigations.

Multiple discriminant analysis of the Heidelberg data, including psychosocial and medical variables, correctly predicted lung cancer with 87% accuracy. Psychosocial variables included aspects of stress research such as the

"number of traumatic life events," as well as personality variables. Hopelessness had "by far the strongest correlation of all variables with lung cancer (0.62), whereas rationality and anti-emotionality [had] a much lower correlation (0.25)" (Grossarth-Maticek, Kanazir, Schmidt, Vetter, 1985, p. 320).

In conclusion, Grossarth-Maticek et al. determined that psychosocial risk factors are important predictors of mortality from cancer, and that factor analysis discriminates which independent variables are important to utilize in research. Therefore, the need for systematic exploration of the possible link between abasement and cancer is supported by the work of Grossarth-Maticek et al. (1982, 1985). The relationship between resignation, one of the aspects of abasement, and hopelessness, Grossarth-maticek's main predictor of cancer mortality, also needs to be evaluated.

Douglas Jackson (1970) also used factor analysis to discriminate the aspects that reliably comprise the trait of abasement. Hopelessness is linked to abasement through resignation. If indeed abasement is correlated with cancer, then Jackson's (1984) specific definition of the trait (see page 6) lends itself to a reliable and detailed description of what adults with a cancer experience regarding their self-abasement patterning.

More specifically, the trait of self-abasement has not been directly researched in connection with cancer; however, this trait may be synonymous with some of the characteristics

identified by Grossarth-Maticek et al. Douglas Jackson in his 1984 research manual defined "self-abasement" in terms such as "self-subordinating," "yielding," "willing to accept an inferior position," "obedient," "deferential," "obsequious," "subservient," "self-effacing," "surrendering," "[resigning]," "apologizing," "[showing a] high degree of humility," "[accepting] blame and criticism even when not deserved" (p. 6). When defining the psychosocial sequelae that predict mortality from cancer, Grossarth-Maticek et al. (1985) include terms similar in meaning to Jackson's such as "hopelessness," "setting oneself aside," "receiving social repression," "need for harmony," "idealization," and "over-adjustment." From my clinical observations, the highly self-abasing person seems to organize his or her view of others as good and of himself or herself as bad, thereby idealizing others. Although good/bad splitting is considered to be normal ego development early in life, it is my opinion that the highly self-abased person remains fixed in this stage. Despite the lack of direct research relating self-abasement with the disease of cancer, the preciseness of definition offered by Grossarth-Maticek et al. (1985) and Jackson (1984), in conjunction with my clinical observations provides a starting point for coming to an understanding of this possible link.

Precedent Setting Research in Health Psychology

This present study on self-abasement and cancer is in the

burgeoning "field of health psychology which bridges the gap between psychology and medicine" (Anastasi, 1982, p. 559). Why do I place this preliminary study in the area of psychology known as health psychology? It is now accepted that "physical health is inextricably interwoven with the psychological and social environment . . . [but health psychologists share a common vision]: the view of health and illness as determined by a variety of biological, psychological, and sociological factors" (Taylor, 1991, p. 6 & p. 8). Health and illness is a broad topic that requires an expansive vision, and the definition of health psychology as put forth by Matarazzo suits my need for an expansive scope on the psychological level. He suggests that:

> Health psychology is the aggregate of the specific educational, scientific and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, the identification of etiologic and diagnostic correlates of health, illness, and related dysfunction and the improvement of the health care system and health policy formation (1980, p. 815).

My expansive vision of health psychology was conceived in my clinical work with adults diagnosed with cancer because the prevailing patterns of this illness have changed from acute to chronic. In our lifetime, one in three will be diagnosed with cancer which is considered to be a chronic disease. The three main chronic diseases of this century: cancer, heart disease and diabetes are the main contributors to disability and death

in North America (Taylor, 1991). By definition, chronic diseases are not curable, but require the interaction of patient and practitioner in order to manage a life with disease. This interaction has expanded my awareness for two reasons: first, because "psychological and social factors are implicated as causes" of cancer; and second, because adults with a cancer diagnosis tend to live for many years during which time psychological issues arise (Taylor, 1991, p. 9). Therefore clinically, I am continuously faced with questions that elicit elusive answers.

Clearly then, a basic assumption of health psychology is that "the mind and the body together determine health and illness" (Taylor, 1991, p. 11). This assumption requires an expansion of the reductionistic views of the medical model in order to include illness and health as an outcome of the dynamic "interplay of biological, psychological, and social factors" which defines the biopsychosocial model (Engel, 1980). Two further assumptions of health psychology suggest wholism rather than dualism and health restoration rather than illness over health. Gerber (1988) refers to wholism as "a synergistic approach which deals with the combined physical, mental, emotional and spiritual aspects of human health and illness" (p. 536). Ironically, dualism, the belief that mind and body are separate entities, is another way of expressing the result of self-abasement which culminates in self-effacement (see Chapter One) or a splitting of the mind from

the body. I believe that splitting as a result of self-abasement in adults with cancer is contrary to wholism, and is therefore a barrier to health. Any treatment of disease or imbalance is "substantially affected by psychological and social factors, and this cannot be explained by the [medical] model," or dualism (Taylor, 1991, p. 12). Therefore, the treatment of splitting must by definition, derive from wholistic approach which enlists the body's ability to be a guide in healing itself rather than merely being diseased. An example of this healing ability of the body is the relaxation process where life of the body transforms from a tense to a state of ease. As tension is reduced in the body, more sensation can be experienced and thus the split can begin to be transformed into a connecting of mind with body through the relaxation process. Body life is a synergistic process that, for the possibility of health, must be viewed wholistically.

Research in the area of coronary heart disease sets a precedent for the present health psychology research in the area of personality and cancer. Psychologists have developed new, psychometric measures that are reported to provide systematic and standardized behavioural information useful to medical doctors. Anastasi states that specialized personality inventories are being standardized along with life-history data research regarding the personality patterns that may be associated with an individual's vulnerability to diseases such as cancer, tuberculosis, and coronary disorders. One of the

best known examples of health psychology research is the "Type-A personality" which is susceptible to coronary heart disease. Friedman and Rosenman (1969) used epidemiological studies, structured clinical interviews, and laboratory testing to analyze verbal content and individual behaviour to validate the Type-A concept. They used both cross-sectional and longitudinal research with large numbers of employed, middle-aged men. Out of this research came Jenkin's Activity Survey (JAS), a 52 item self-report inventory in which "Type-A behaviour is characterized by extreme competitiveness, striving for achievement, aggressiveness, impatience, haste, restlessness, and feelings of being challenged by responsibility and the pressure of time" (Jenkins, Zyzanski, & Rosenman, 1979, p. 3). The JAS has adequate item and test-retest reliability and concurrent validity has been established. The test was standardized on a sample of two thousand five hundred men. However, relatively few female groups have been tested. Means and standard deviations are also provided (for further statistics see Anastasi, 1982, p. 560).

Therapy with coronary heart disease patients has been shown to decrease the recurrence of cardiac disease (Friedman, et al. 1984). Given this finding, it becomes more difficult to avoid the idea that there is a predictive link between Type-A behaviour and coronary heart disease. Friedman, et al (1984) have shown that Type-A behaviour can be changed. By comparing

a behaviour therapy group of cardiac patients with those who received heart-related counselling only, they found that the cumulative cardiac recurrence rate was 7.2% over a three-year period in groups who received behaviour therapy and 13% recurrence rate for groups who received heart-related counselling only. Eysenck (1985) believes that the evidence is mounting for such Type-A behaviour to be biosocially linked to and predictive of coronary heart disease. Moreover, further research (see reviews by Hinkle, Whitney & Lehman, 1968; Spielberger, Crane, & Rosenman, 1982) expands on the meaning of the Type-A concept by suggesting that achievement and status climbing may not be as related to coronary heart disease as is, ". . . the frustration and anger of motivated strivers whose achievement lags behind their ambition" (Anastasi, 1982, p. 560).

Precedent has been set for the use of well-tested instruments in the measurement of personality patterns associated with susceptibility to disease. Factor analytic studies and correlational research points out that the area of health psychology includes many dimensions. What is important is to identify these many dimensions and then determine proneness to disease (Eysenck, 1985).

The Concept of Multidimensionality and Disease

The concept of multidimensionality can be used very broadly in that it can "refer to the total spectrum of human

energies, [such as dimensions like the] physical, etheric, astral, mental, causal, and higher spiritual levels" (Gerber, 1988, p. 538). As suggested in Chapter One of this study, multifactorial (a word that from a statistical point of view can be interchanged with multidimensional), interactions are responsible for the onset of disease (Taylor, 1991). One dimension of these multidimensional interactions that are involved in the etiology of disease is personality, as it seems likely that personality traits interact to influence illness (Levy, 1985). Depending on the scope one refers to, personality can be a multidimensional concept. The traits of abasement, need-for-approval and dominance are then dimensions of the concept of personality. If the similarity or dissimilarity of dimensions such as abasement are assessed using psychological distance theory, the traits can be measured mathematically in relationship to each other (Jackson, 1969). Therefore, in this study each of the personality variables--abasement, dominance, and cancer state--represents a dimension, or a measurable scope of the nature of the personality variable or trait. The interactions, of these variables, are represented in a multidimensional way.

The concept of psychological distance is one of the foundation theories for the measurement of multidimensional scaling. Jackson (1969) stated that:

> traits close together in a space representing psychological distance would tend to be seen as implying one another, whereas traits far apart would tend to be viewed as independent.

> Furthermore, the dimensional interpretation of these distances might very well provide a framework for summarizing the important categories of trait inference and of indicating their relationships to one another. It is to be noted that such a formulation is an additive model in the sense that the units of measurement are Euclidean distances which can be interpreted in terms of linear algebra (p. 234).

Jackson equates his personality variables to the apex of a graph. He points out that since the traits have been chosen in a manner which makes them as separate (independent) as possible, they could be represented as perpendicular to each other. This representation is the commonly used one for multidimensional space in mathematics. Jackson's multidimensional scaling results identify abasement and dominance as independent of each other or far apart in terms of psychological distance. Using Jackson's multidimensional scaling method, we not only see that abasement is a dimension that is independent of dominance, but is identified with high correlations of items or questions that are relevant to abasement and irrelevant to dominance. As Jackson (1970) stated, "items selected because they correlate more highly with the appropriate scale of necessity will be more homogeneous, and suffer less from the intrusion of irrelevant content variance" (p. 79). Using the scaling model to select items considers the smallest possible dimensionality. Jackson's (1969) "direct attempt to treat psychological distance as Euclidean distance" allows for the rejection of unidimensional scaling as too simplistic in the

multidimensionally complex areas of study such as personality and disease (p. 228).

Jackson's (1984) Personality Research Form (PRF) derives from the applications of multidimensional scaling which allows for the formulation and measurement of personality dimensions and their relevant items. It is the measurement of the dimensions that clarifies whether a very low score "[signifies the] absence of [the] trait or the presence of [it's] opposite" (Jackson, 1984, p. 25). From this clarification came the conception of all PRF personality traits [as] bipolar [where] half of the items are written in terms of one pole of the dimension, and half in terms of the others" (Jackson, 1984, p. 25). Therefore, a high scorer in the dimension of abasement is self-effacing, but a low scorer is aggressive. A high scorer in the dimension of dominance, which is independent of abasement, is controlling and forceful, but a low scorer is submissive. "This explicit bipolarity of PRF scales . . . [defines] both ends of a dimension with items [giving the] advantage of more exactly specifying what was being measured . . . signifying the presence of important characteristics which serve to differentiate the subject from others" (Jackson, 1984, p. 25). The interrelationships between variables can also be identified. For example, dominance is independent of abasement, and yet a low scorer on the dominance scale is described as submissive, an adjective describing the trait of abasement. This would be equivalent to

the origin (0,0) if we were graphing dominance on one axis and abasement on the other axis. The multidimensional scaling method of personality assessment brings exacting definitions of variables and their interrelationships to multivariate research in the area of personality and disease.

Jackson has given us the independent dimensions on which to discuss personality, and I have added an additional dimension, cancer state. A multidimensional view of disease has not been well accepted. The germ theory of illness that Western medicine has referred to since Pasteur, has guided the thinking about disease as unidimensional, with one specific physical cause of the illness and one specific remedy. Factors or dimensions such as nutrition, alcohol, smoking, the air we breathe, trauma, or behavioural and personality variables have not been given much credence or attention over the last one hundred years. Another reason for this narrow perception of disease is that although for several centuries many doctors put forth concepts of psychosomatic disease, these theories were dismissed by sceptics (also doctors) as being based only on speculation (Eysenck, 1985). According to Antonovsky (1979) it is "amazing" that any of us remain alive when one considers the increasingly high statistics on chronic disease, stress and accidents. Yet "why a particular set of somatic conditions need not inevitably lead to illness, remains difficult to answer" (Taylor, 1991, p. 12). For this reason, he suggests that "it makes the most sense to picture answers on a complex

multidimensional continuum" (p. 15). As Antonovsky sees it, such a continuum takes into account the dynamic movement between healthfulness at one end of the scale, and disease and other threats to life at the other. This continuum, if applied to distance between health and disease, may also be measured algebraically and a multidimensional scaling method may be utilized. This is an exciting thought that is the stuff of future research.

Over the last two decades, however, research has gradually challenged the scepticism about multidimensional views of disease. For example, Eysenck (1985) reviewed the available literature on dimensionality and cancer and identified that the standardized mortality for the war veterans he studied showed that the more advanced the veteran's rank the lower his mortality rate. Previously, the Metropolitan Life Insurance Company (1973) in New York State identified that congressmen and state legislators also had a very low mortality rate (Eysenck, 1985). Seltzer & Jablon advanced the idea that "perhaps advancement in rank is also affected by factors which have some underlying biological basis" (Seltzer & Jablon, 1977, p. 565). They concluded that advanced performance and leadership qualities may positively correlate with greater longevity. Seltzer and Jablon began to speak out for qualities or characteristics of human beings as being based in biology. Biologists take this argument further and state that if human characteristics (such as performance)

are biologically based, then they are genetically endowed. I will come back to this discussion later on in this section.

In recent literature, many human characteristics and personality traits have been statistically related with the biological states of health and disease. Antonovsky (1987) and Kobasa, Maddi and Kahn (1982) asserted their view that it is important to study characteristics that help us resist disease. This relationship will be discussed further in the section on personality traits and cancer.

Barquero, Munoz, Jauregui (1981) have shown that neuroticism is one personality trait that has been linked statistically to physical disease. However, it is not easy to understand the relationship between personality traits and disease. Totman, Kiff, Reed and Craig (1980) demonstrated that introversion and recent life stress were predictive of colds and of the severity of colds. However, introversion and stress were not significantly correlated with each other. This leads to difficulty identifying the relationships between these two variables. One wonders why introversion and stress rather than just introversion or just stress would relate more to colds. Therefore, it is important to do multivariate analysis of personality traits and disease in order to clarify the inherent obscurity of one-to-one correlations.

We are beginning to discover that disease is not caused simply by germs or external habits such as smoking. Doll and Peto (1976) contended that giving up smoking would reduce the

mortality rate due to cancer. Friedman, Siegelaub, Dales and Seltzer (1979) challenged Doll and Peto's hypothesis by doing research that resulted in the identification of quitters as being more like non-smokers than they were like smokers in terms of various health checks regarding heart disease. Eysenck (1985) in his review of the literature suggests that the evidence relating to the effects of smoking on cancer is insufficient to conclude that smoking is causal. He suggests that Doll and Peto's design assumes that the quitters and the non-quitters in their smoking groups were respectively equal with regard to personality, health and other relevant variables. Eysenck (1985) suggests from these results that methodological research designs based on self-selection produce untrustworthy results. Grossarth-Maticek, Kanazir, Schmidt and Vetter (1985) directly investigated other variables in their prospective study of 1,353 subjects and found that smoking was not as strongly associated with prediction of cancer as were personality variables such as putting oneself aside. Disease, therefore, can result, in theory, from the individual being ill-at-ease with some aspect of his or herself. Being ill-at-ease may be the result of the bidirectionality aspect, i.e. disease changes a person's self-image and a person's self-image may lead to disease. People are not unchanging and static; we are changing, multidimensional, dynamic organisms.

How do we best research this dynamic process in order to include the many dimensions involved? Whatever form of research is used it seems important to study the organism as a whole so that the dynamic and multidimensional movement of personality can be investigated. Medical science continues to lean heavily on the germ theory and its effect on physiology. Sociobiology posits a biological basis of social living, a theory which may lead to overuse of genetic endowment. Proponents of social and psychological concepts often fail to consider the importance of behaviour, personality, environment and social norms on our biology and specifically malfunctions of our biology, i.e. cancer. Two concerns arise here: neither medical science, sociobiology, sociological, and psychological research have found on their own the definitive answer to cancer; moreover, the distrust and competitiveness between these research groups has led to the perpetual narrowing and isolating of issues. Each view is reductionistic. Scientific cause and effect reductionism alone does not aid our understanding of the dynamic human being.

Ruth Hubbard (1984), professor of biology at Harvard University, argued in regard to genetics that "at the simplest level . . . we can occasionally pinpoint a simple gene that affects that particular trait" (p. 6). However, she contends:

> the moment we shift from that rather simple level to most traits, . . . that is, to all social traits, we leave the territory of single gene affect and begin to deal with interactions among large numbers of genes. And once we get to that point, we have no adequate theoretical tools, and .

> . [perhaps] cannot develop any adequate theoretical tools, because it is undoable to tease apart the genetic from the environmental, social and so on . . . Environmental mean[s] . . . at the level of the cell, at the level of the tissue, at the level of the organism. And genes are part of a complicated and interacting system. Genes don't do anything on their own by themselves, and the fact that we pinpoint genes is overly simplistic and gets us off the track (p. 6).

Multidimensionality, therefore, includes the complex and dynamic flow of systems, a view more suited to the human energy system that we are trying to understand and to heal.

Hubbard goes on: "Biology and our social living interact and can't be sorted out. And by that I don't just mean that we don't have the conceptual tools to do it, I mean that it can't be done" (p. 1). She does not separate the two. Therefore, she contends that "there is no such thing as human biology in the pure or as a biological basis for what we are" (p. 5). Hubbard is interested in how society might have affected our ways of conceptualizing events in biology. She states that biology and culture cannot be separated from one another except as part of an intellectual exercise. She writes that, "our bones, our muscles, our sense organs, our hormones, all develop and function in interaction with the ways in which we live" (p. 1). For her, the biological and social are interconnected.

Although medical science attempts to isolate cancer in the body as a physical phenomenon and treats it as such, I contend, like Hubbard, that the body must be studied in a broader context which includes the interaction between social/cultural constructs and biology. When examining the

physiological effects of a malfunction such as cancer on the body one must do so within the context of the human being as a social organism.

Thus, in this context, my study involves the interaction between self-abasement, a personality trait, and cancer, a biological malfunction. Such a perspective takes into account the dynamics of the dimensions of personality. Clients themselves have requested help in order to discover how to transform the pattern of self-abasement. If biology and social constructs are entwined, then this desire to heal must come from the people, not from the researcher or therapist alone.

Personality Traits and Cancer

Kobasa (1982) reports that the two basic aspects of personality comprising coping are cognitive appraisal, and the ability to take action. The cognitive assessment gives rise to experiencing stressors in a certain way and assigning certain meanings to them. Action results from the initiation of appropriate activities based on how stressors are perceived. Kobasa believes that "personality dispositions can influence coping processes and that this may be the mechanism whereby personality exercises a buffering effect on stressful events" (p. 169). However, a buffering effect would be the result of a personality trait that the stressed individual assesses as self-protective. According to Kobasa (1982) there are specific personality dispositions that buffer the effect of stressors:

> [There] are those that have the cognitive appraisal effect of rendering the events as not so meaningless, overwhelming, and undesirable, after all, and the action effect of instigating coping activities that involve interacting with and thereby transforming the events into a less stressful form rather than avoiding them (Lazarus, 1966). Persons with personality dispositions of this sort possess a valuable aid in avoiding illness-provoking biological states such as adaptational exhaustion (cf. Selye, 1976) or depressed immulological surveillance (cf. Schwartz, 1975). They should be able to remain healthy while experiencing events that would be debilitating for others without those personality dispositions (p. 169).

Kobasa (1982) suggests that "hardiness" may be the trait which buffers illness. Hardiness may be considered a unidimensional variable or it may include subscales of "control," "commitment" and "challenge." Specifics are unclear as yet, however, personality traits do seem to represent an important component of the relationship between stress and illness. If the enduring personality trait wears down the body's defenses, exhausting the individual, then illness may result.

Kobasa believes she has demonstrated the buffering effect of "hardiness" on stressors. If this is true, then she should have produced a scale which measures resistance to exhaustion. This would imply that her hardiness scales could subsume Jackson's scales. However, she used five scales which were rather unmanageable. Furthermore, her "stressful life events" were taken from a five year period before the onset of the illness, a space of time Kobasa herself suggested was too long for the effect of the event to be a reliable measure. Rushton

(1990), who replicated and tested the validity of "hardiness" as a personality style, argued that "hardiness is not a significant predictor of illness" (p. ii). The validity of the third generation hardiness test is questionable at this time and differing results are obtained if different statistical analyses are used (Funk & Houston, 1987). Rushton contended that: "future research should concentrate on establishing the nature of hardiness" which would open the door for research into other personality traits, such as self-abasement, and their relationship to hardiness (p. 42).

With regard to personality, one could address any aspect of what has been known as the "health ease/dis-ease continuum" (Antonovsky, 1979). Antonovsky and Kobasa argue for researching the "origins of health" because they are interested in "why people are located toward the positive end of the health ease/dis-ease continuum, or why they move toward this end, whatever their location at any given time" (Antonovsky, 1987, p. xii). In his study Antonovsky coined the term "salutogenic orientation," which he maintained was important because stressors are rampant and yet people survive and even thrive. Therefore, personality variables that are effective in combating stressors deserve to be studied because such variables can show how people survive stressors.

Antonovsky contended that when "a stressor results in a state of tension . . . whether the outcome will be pathological, neutral or salutary depends on the adequacy of

tension management. The study of factors determining tension management, then, becomes the key question of the health sciences" (Antonovsky, 1987, p. xii). Antonovsky refers to any phenomenon that is effective in combating a wide variety of stressors as "Generalized Resistance Resources" or G.R.R.'s. G.R.R.'s help the individual develop a strong sense of coherence, consistency, and ability to influence the outcome of the load exerted by the stressor. The sense of coherence is defined as "a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic, feeling of confidence that one's internal and external environment are predictable and that there is a high probability that things will work out as well as can reasonably be expected" (Antonovsky, 1987, p. xiii). Kobasa's personality disposition named "hardiness" is considered to be a resistance resource which would be located on the "health ease" end of the health ease/dis-ease continuum.

On the other hand G.R.R.'s may be viewed as "resistance deficits." A resistance deficit is "a characteristic that introduces entropy into the system--that is, a life experience characterised by inconsistency, under or overload, and exclusion from participation in decision-making" (Antonovsky, p. 28). A resistance deficit would be located on the "dis-ease" end of the continuum and as Antonovsky acknowledged, stressors must continue to be identified and measured for there to be a theoretical base. Out of this theoretical base

can then come tools which advance health, but, a thorough understanding of the stressor must come first. This study acknowledges self-abasement as being on the dis-ease end of the continuum. Self-abasement would be an enduring stressor that needs to be identified. The stressor may either be a significantly or insignificantly co-related trait within the lives of those with cancer as compared to those without cancer. The capacity of this trait to predict incidence of cancer may be explored if the trait is found to be significant. However, such a prediction would be premature at this time.

The next important exploration focuses on personality traits or characteristics with regard to cancer specifically rather than illness generally.

Traditionally, research has been preoccupied with areas of cancer and personality behaviour deformations or behavioural dysfunction such as neuroticism, introversion, extroversion and psychosis (reviewed by Bahnson & Bahnson, 1964 a; Eysenck, 1985; Kissen, et. al, 1969; Solomon, 1969). Although these attributes can be found in other dysfunctional behaviours, they will eventually deteriorate the health of an individual. Therefore, over long periods these dysfunctional behaviours will have a negative effect on the body's immune system. This may eventually result in cancer. Selye's (1976) research indicates that, "our difficulties are not caused by the external agent to which we are exposed but by our own

excessive adaptive mechanisms . . . stress diseases . . . are not the direct results of any pathogen, but of our defective bodily or mental reactions to the stressors encountered in daily life" (p. 84). "How you take it" is more important than the "external agent" itself.

There have been retrospective studies which argue that there is a relationship between psychosocial and physiological functions pertaining to malignancies (Bahnson & Bahnson, 1969; Kissen, 1966, 1969; LeShan, 1966, 1989). Researchers who have completed prospective studies have further challenged our disbelief and our scepticism. Their results demand increasingly serious acknowledgment of the psychosocial and physical interconnections with cancer (Hagnell, 1966; Thomas, 1983; Grossarth-Maticek; Kanazir; Schmidt, Vetter, 1985). Much of this research continues to be neglected (Becker & Selden , 1985, p. 221). Methodological and substantive difficulties have been found with many of these research projects (Fox, 1978; LeShan, 1960). Yet, personality traits are being linked with increasing confidence to poor tumour response and the development of cancer (reviewed by Eysenck, 1985; Grossarth-Maticek, Kanazir, Schmidt, Vetter, 1985; Levy, 1985; Solomon, 1969). It is important to discuss avoidance, defense against hostility and low self-esteem because they are related to each other with respect to cancer.

Avoidance

People who have a high-need-for-approval lack ways of reducing painful feelings of inconsistency when acquiescing in order to gain public approval. However, this avoidance of conflict allows a self-protective bubble in which they dwell "to avoid threats to self-esteem, anticipated social rejection," and to avoid "the necessity of having to acknowledge that one believes oneself to be a bad and worthless person" (Marlowe & Crowne, 1964, p. 130).

Marlowe-Crowne (1964) continue, "this does not occur for low-need-for-approval subjects". "High-need-for-approval" individuals are avoidant because they experience a chronic dependency on positive self-evaluation and positive evaluations by others. I have noted that adults with cancer repeatedly avoid self-reports of distress, and my observations have been supported by the findings of Derogatis, et al. (1979). Such avoidance has been associated with more rapid metastatic spread of breast cancer (Derogatis, et al., 1979; Levy, 1985; Jensen, 1984), decreased activity level of natural killer cells and increased levels of cancer recurrence nine months later in melanoma patients (Visintainer & Casey, 1984). Kobasa, et al., (1982) identified avoidance and passivity as rendering patients unable to cope with stressful stimuli which increase host vulnerability to disease.

Defence Against Hostility

Marlowe and Crowne (1964) found that people experiencing prolonged stressful stimuli had one of two things happen: the feeling generated by the emotional stimuli was not felt, or the feeling generated by the emotional stimuli was felt in the physical body, and these people were found to have lower-need-for-approval. Emotional inhibition results in the provoked person not feeling his/her anger. In contrast, repression exists in one who feels his/her anger but consciously distorts what the anger means to him/her. The high-need-for-approval individual's defenses against hostility include repression, conforming, and submissive behaviour. The approval dependent person's restricted behaviour may also include rigidity, in regards to level of aspiration, as a defense. Repressive coping styles have been linked to poor tumour response (Levy, 1985; Schwartz, 1983) and rigid self-protection heightens host vulnerability to disease (Kobasa, 1982).

Low Self-Esteem

From the evidence above it would follow that defenses against hostility would be necessary for an approval dependent person. This person is chronically in need of receiving positive evaluations from others and of proving him or herself to be perfect. Hostility, particularly in our culture, invites the "threat of alienation from others, social rejection,

unfavourable evaluations and the resulting peril of damage to self-esteem" (Marlowe & Crowne, 1964, p. 133). Those who are most influenced by persuasive communications by others are approval dependent and low in self-esteem. These individuals are also submissive, weak, passive, immature and repressed, factors which correspond with cancer research where passivity and repression strongly correlate with worse health outcome and worse cancer outcome (Grossarth-Maticek, et al., 1982; Kobasa, et al., 1982; Levy, 1985). According to Marlowe and Crowne (1964), "goal-setting rigidity of high-need-for-approval-low-expectancy [for success] subjects increased under threat to self-esteem" (p. 95). The approval dependent behaviour is used to protect a vulnerable self-esteem, a vulnerability that has been shown to correspond to illness and perhaps cancer.

Avoidance, defense against hostility and low self-esteem are defenses as understood in psychology, but I hypothesize that, in the person with cancer, these defenses are so predominant as to be discussed as personality traits. The premise of this thesis is that prolonged self-abasiveness leads to the defenses described above which in turn rebound and affect the self-abasement patterning by reinforcing it.

Chapter Three

Method

Participants

The 82, white, middle class, participants were drawn from two groups of adult volunteers. They were divided equally by age and sex into two equal groups: those who were medically diagnosed with cancer, and those who were medically healthy and designated as not having cancer. Age ranged from 40 to 85 years. I categorized the participants as either 65 years of age or younger, or as older than 65. Subjects in the two groups were matched for age (within a three year range).

The 41 participants in the cancer group were referred by 15, white, middle class, family doctors. Seven doctors were women and eight were men. All were from the city of Victoria. The doctors reviewed all of their patients, who were in cancer remission and being monitored, against the research criteria. This procedure was intended to provide a control for the doctors' potential selection bias. Moreover, the doctors were blind to the particular topic to be researched when they referred their patients to this study.

Once the group with cancer had been tested, the 41 matched participants required for the no cancer group were also referred by the same medical doctors. The referring physician proclaimed each member of this group to be healthy.

In order to assure the control of more confounds, further exclusion criteria were applied by the experimenter to each of the groups. Based on medical history, each participant was screened and excluded from the study if there was a diagnosis of skin or brain cancer, in-patient psychiatric history, mental retardation, HIV virus or A.I.D.S., a major head injury, and/or mental inadequacy due to drug or alcohol addiction. Those with cancer were accepted into the study provided they were not in a state of crisis as evaluated by their doctor and the experimenter. This meant that they were at least six months post diagnosis and post relapse. There were no other major illnesses diagnosed within this group. Those adults referred to the group with no cancer had no recent experience of a relative or close other with cancer.

To summarize, the main attribute variables were age, sex and health state. The exclusion criteria as stated above, were applied to the appropriate group. A group of adults diagnosed with various types of cancer was compared with a group of healthy adults in a separate matched group.

Instrumentation

Each volunteer was asked to complete the two shortened self-report inventories which provided data on three personality traits: abasement, need-for-approval, and dominance. Data for the abasement and dominance scales was derived from Jackson's (1984) Personality Research Form-E

which was shortened by Jackson, for ease in test completion, to 96 items. Marlowe and Crowne's (1964) Social Desirability Scale measured the trait of need-for-approval and was administered in its full 33 item format. For analysis the 33rd question was eliminated due to a typographical error found after testing.

The Personality Research Form-E (PRF-E)

The PRF-E assesses normal psychological parameters that are applicable to a wide range of human functioning using 22 dimensions of personality in all. Norms for this measure of personality apply to a range of 12 to 40 years in both male and female populations. The PRF was developed in 1967 utilizing highly theoretically relevant scales derived from empirical item selection which correlated highly with rational methods of judgement of items. The first step of personality scale construction demanded specific definitions of each variable and the application of convergent and discriminant validation. Response style biases such as acquiesence and desirability were also taken into consideration and were controlled. The development of the PRF implied structural homogeneity within the construction model.

The PRF-E's range of reliability estimates were .80 to .94 with the median being .925. Scales "conformed very well to expectations of structural homogeneity" (Jackson, 1970, p. 72). Based on repeated collections of norming data, Jackson

(1970) stated that "there was substantial convergent and discriminant validity associated with PRF-E scales" (p. 88). His extensive research with the PRF-E scale assures that the terms of self-abasement and dominance are defined concisely and have the "properties of reliability, substantive generalizability, and validity" as required by all testing measures (Jackson, 1984, p. 4).

The shortened PRF-E measure used in the present study utilized six scales which were abasement, desirability, social recognition, succorance, understanding, and dominance. Jackson, the expert and designer, determined that the pared down version of the PRF-E would retain the properties of validity and reliability. He stated that, "In my experience with the PRF test, there would be more reliability if sixteen items were used, but that the six items chosen would remain reliable" (interview with Dr. Jackson, 1992, University of Western Ontario). I predicted that abasement would be the main trait interacting with cancer. The scales of "desirability," "social recognition, and "succorance" all include some aspects of approval and can be used as checks and balances with the Marlowe and Crowne version of approval needs. The scale for "understanding," tests for an adequate intellectual approach by the testee. The sixth trait to be tested was "dominance" which was chosen because it is in contrast to abasement. Dr. Jackson also felt that the groups would take the testing seriously, eliminating the need for the "infrequency" scale

which identifies non-serious participants. All six scales were approved by Dr. Jackson, author of the PRF-E, as adequately masking content and giving adequate diversity to this study. Jackson stated that it is possible to treat each PRF-E scale, including the pared down scales, as distinct, and to have confidence that each is providing a unique contribution to the assessment.

Marlowe-Crowne's Social Desirability Scale

Even though a social desirability scale has been built into the PRF, due to the need to refer to the theory of the approval motive research, participants were further tested for social desirability using the Marlowe-Crowne scale (1964, pp. 23-24). Therefore, because the PRF desirability scale does not seem to be generalizable to the theory of the approval motive by Marlowe-Crowne, both scales were used. Realizing that need-for-approval participants will ironically try to gain the tester's approval by giving the "right" answers during testing, Marlowe-Crowne developed a scale which has been found to control this need for the tester's approval. Consequently, their results suggest that the Social Desirability Scale is valid as a measure of a person's need-for-approval outside of the test situation. They found that the test was predictive of the need-for-approval as behaviourally lived out by the subjects in their lives (p. 196).

The Marlowe-Crowne scale was tested for internal consistency and test-retest correlations. The correlation for test-retest of .88 was calculated which suggests that a sufficient level of reliability was achieved (pp. 24-25). (Reproduction of PRF-E adapted verson and M-C scale source can be found in Appendices A & B).

Procedure

I requested and received approval for the proposed research involving human subjects, from the recognized ethical and legal Human Subjects Committee of the University of Victoria. Upon receiving approval from the Human Subjects Committee, the experimenter began to make phone calls to medical physicians in the city of Victoria asking if they would be interested in taking part in this study. Physicians were randomly selected and were recruited until 15 doctors, eight males and seven females, agreed to participate. Twenty-two physicians in total were contacted and seven refused. Cooperative doctors were then given a letter (see Appendix D) explaining the selection and exclusion criteria to be used for the selection of volunteer participants. Subjects for the cancer group were referred first, so that the no cancer group could be matched for sex and age with the cancer group. Each physician informed me of the names, ages, dates of diagnoses, relapses (if there had been any), and phone numbers of the potential participants who had agreed to either take part in

the study or talk with me further. A phone call was made to each subject to request voluntary participation in the research. Each volunteer participant was asked to meet for an initial interview during which information from "Description of Study (take home) form" was given; informed consent was obtained in writing as part of this process (for forms see Appendix D). Subjects were informed of their right to withdraw at any time without any bias to their health care. Time was then set at their convenience and in a place of their convenience, usually their home, that was free of distraction for them. I then met with them, one at a time, and applied the two questionnaires in alternating order. Questionnaire completion took them forty to eighty minutes, a range that I observed seemed to be dependent on health status rather than age.

I preserved the subject's anonymity and maintained confidentiality by assigning a number to each subject; and I documented this number and the corresponding subject's name in a code book. From that time on, all information completed by the participant was identified only by code number. At the end of the study, the code book was destroyed.

As well as the risk of boredom in completing self-report inventories, there was a chance of triggering personal information that may have been disturbing or bothersome to the person completing the tests. As a therapist, I was willing to assist any subject in seeking professional counselling or

other appropriate support as required. Debriefing was carried out. Information on what the research was about as well as test results was made available to each subject as desired.

Analysis of the Data

The means for the dependent variables; abasement, need-for-approval, and dominance scores were calculated to describe the samples studied. The three attributes that were used to describe the sample were sex, age and cancer state. The degree to which the three dependent variables varied were then explored through the application of multivariate analysis of variance (MANOVA). These data were then interpreted as the multiple measures of interaction between the three attributes and the three dependent variables as calculated. Multivariate statistics was the analysis of choice because I "simultaneously [analyzed] multiple dependent and multiple [attribute] variables. This capability is important in both non-experimental (correlational or survey) and experimental research . . . The terms [independent and dependent variable] are used for convenience rather than to indicate that the variables were derived from experiment" (Tabachnick & Fidell, 1989, p. 2). The individual analysis of variance (ANOVA) tables were calculated and included as well as their corresponding Pearson product--moment correlation coefficient--a bivariate statistic.

Chapter Four

Results and Discussion

Proper analysis using MANOVA requires that we be cognizant of the effect of the order in which the variables are entered into the procedure. All orders for the three attribute variables of age, sex, and health state were analyzed using the MANOVA, giving identical results. Therefore, there was no ambiguity in the analysis. The results of the analysis of the data on abasement, dominance, and need-for-approval will be reported consecutively.

Abasement

There were no significant main effects of sex, age, or cancer state on abasement scores. There were no significant two-way interactions of sex with age, sex with cancer, or age with cancer on abasement. However, there was a significant three way interaction of sex with age with cancer state on abasement, F (1, 74) = 5.487, p. <.05 (see Tables 1 and 4, and Figure 1).

The findings of this study supported the research hypothesis that abasement scores were significantly different for cancer versus non-cancer groups when the interactions with sex and age were considered. Results showed that for abasement scores there was a significant relationship, not just with cancer and abasement alone, but rather when all three

Table 1

Descriptive Statistics for Abasement Scores

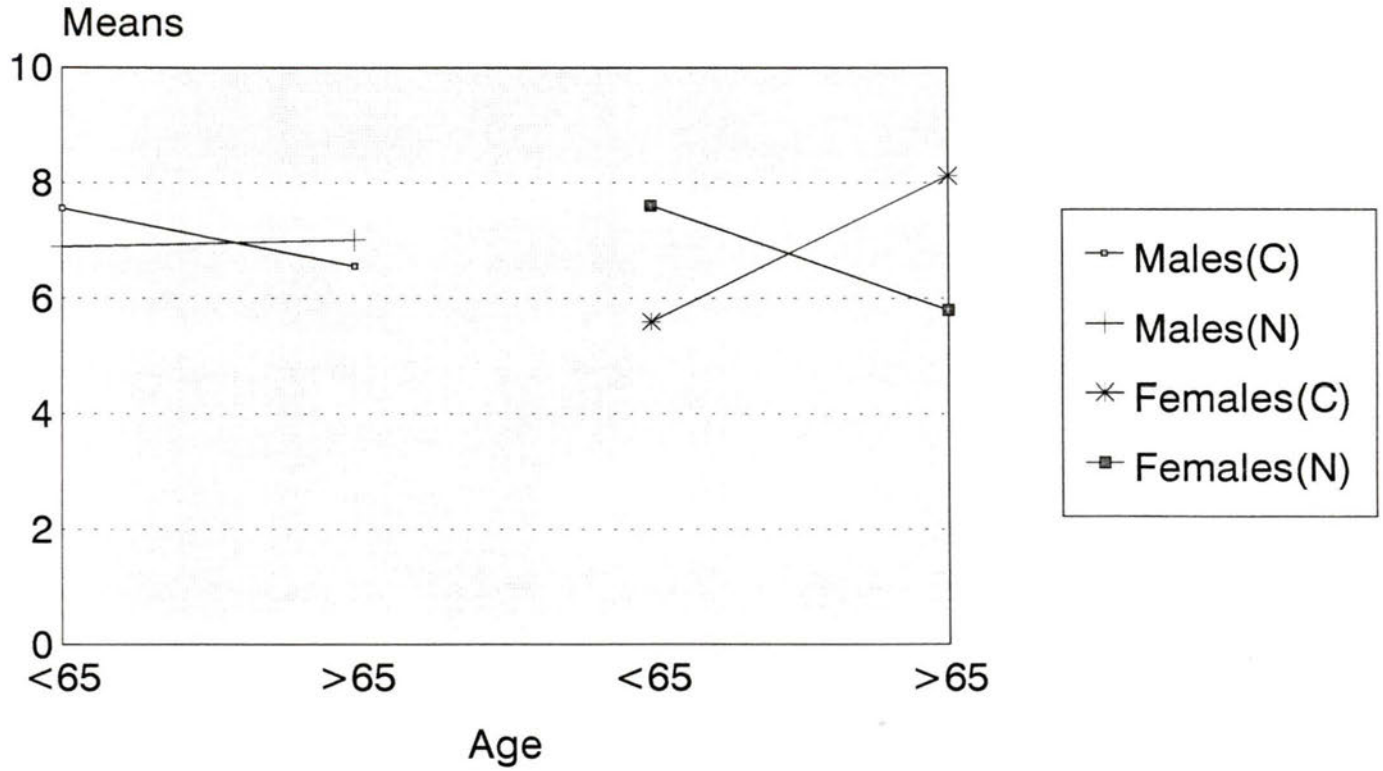
CANCER	Mean	Std. Dev.	N	Range
MALE				
65 & Under	7.556	3.678	9	3 to 13
Over 65	6.556	1.590	9	4 to 9
All Males	7.056	2.796	18	3 to 13
FEMALE				
65 & Under	5.600	1.957	15	2 to 10
Over 65	8.125	1.553	8	6 to 11
All Females	6.478	2.172	23	2 to 11
All Cancer	6.732	2.450	41	2 to 13

NON-CANCER	Mean	Std. Dev.	N	Range
MALE				
65 & Under	6.889	3.516	9	1 to 12
Over 65	7.000	2.062	9	4 to 10
All Male	6.944	2.796	18	1 to 12
FEMALE				
65 & Under	7.600	2.197	15	4 to 11
Over 65	5.875	3.137	8	1 to 11
All Female	7.000	2.629	23	1 to 11
All No-cancer	6.976	2.669	41	1 to 12

Table 4. Summary of MANOVA Tables for Abasement Scores

Source	SS	df	MS	F	P	r
Sex	1.328	1	1.328	0.210	0.648	0.050
Age	0.002	1	0.002	0.000	0.988	0.001
Cancer	1.220	1	1.220	0.193	0.662	0.048
Sex x Age	3.446	1	3.446	0.545	0.463	0.080
Sex x Cancer	0.653	1	0.653	0.103	0.749	0.035
Age x Cancer	15.176	1	15.176	2.398	0.126	0.169
Sex x Age x Cancer	34.721	1	34.721	5.487	0.022	0.256
Unexplained	468.283	74	6.328			
Total	526.244	81				

Figure 1



Means for Abasement as a Function of Age by Sex by Cancer State

variables of age, sex, and cancer state were considered in interaction. This means that abasement was not independent of age, sex, and cancer state. Moreover, the relationship between cancer and abasement scores differed for the various combinations of age and sex. For the healthy group, the prediction that women had higher abasement levels than healthy men was supported.

Abasement scores were significantly different for cancer and non-cancer groups for women over 65 (M=5.88 no cancer, M=8.13 cancer), and for men 65 and under (M=6.89 no cancer, M=7.56 cancer). There was little difference between no cancer and cancer group levels for men over 65 (M=7.0 no cancer, M=6.56 cancer). The relationship between abasement and cancer scores was inverse for women 65 and under (M=7.6 no cancer, M=5.6 cancer). When comparing cancer and non-cancer groups for men over 65 years and for women 65 years and younger, abasement scores were not greater in the cancer group.

When analyzing abasement scores for the cancer group only, there were no simple main effects for age or sex. There was a significant interaction between sex and age on abasement, F (1, 37) = 5.584, p. <.05 (see Table 5, and Figure 1). Within this group, women 65 and younger showed lower abasement scores compared to women over 65 (5.6 for $\leq$65 to 8.13 for >65). Conversely, men's scores in the younger age group were higher than the older age group's

Table 5. Summary ANOVA Tables for Abasement Scores for Cancer Group

Source	SS	df	MS	F	P	r
Sex	1.922	1	1.922	0.357	0.554	0.089
Age	7.742	1	7.742	1.440	0.238	0.179
Sex x Age	30.022	1	30.022	5.584	0.023	0.353
Unexplained	198.919	37	5.376			
Total	240.049	40				

scores (7.56 for ≤65 to 6.56 for >65). When comparing abasement means between women and men in the cancer condition, men (7.56) scored higher than women (5.6) at the age of 65 and under, and women (8.13) scored higher than men (6.56) when over 65 years of age.

As expected in the rationale for this study, the non-cancer group women (7.6) 65 and under have higher abasement scores than men (6.89) of the same age. No age effect was found for men; the younger men (6.89) have practically the same abasement scores as older men (7.0). Women's scores go from 7.6 to 5.88 from the younger to the older age group. According to the analysis of variance, however, none of these differences were significant (see Table 6).

Dominance

Dominance scores were measured to test for compensatory effects to abasement. As expected, dominance scores were not significantly correlated with the cancer state as a main effect. There was a significant difference in the mean dominance scores between the sexes (F (1,74) = 10.719, p. <.05) and between the age groups (F (1, 74) = 8.09, p. <.05). There were no significant two-way interactions of sex with age, or sex with cancer, or age with cancer on dominance scores. There was no significant three-way interaction of sex with age with cancer on dominance (see Tables 2 and 7). The

Table 6. Summary ANOVA Tables for Abasement Scores for Non-cancer Group

Source	SS	df	MS	F	P	r
Sex	0.059	1	0.059	0.008	0.929	0.014
Age	7.435	1	7.435	1.021	0.319	0.162
Sex x Age	8.145	1	8.145	1.119	0.297	0.170
Unexplained	269.364	37	7.280			
Total	284.976	40				

Table 2

Descriptive Statistics for Dominance Scores

CANCER	Mean	Std. Dev.	N	Range
MALE				
65 & Under	9.556	3.539	9	4 to 14
Over 65	10.000	4.500	9	2 to 16
All Males	9.778	3.934	18	2 to 16
FEMALE				
65 & Under	8.400	4.239	15	1 to 16
Over 65	5.375	3.114	8	0 to 9
All Females	7.348	4.086	23	0 to 16
All Cancer	8.415	4.153	41	0 to 16

NON-CANCER	Mean	Std. Dev.	N	Range
MALE				
65 & Under	11.667	3.428	9	4 to 16
Over 65	6.667	3.775	9	0 to 13
All Males	9.167	4.342	18	0 to 16
FEMALE				
65 & Under	7.667	3.792	15	1 to 12
Over 65	5.250	3.454	8	1 to 11
All Females	6.826	3.786	23	1 to 12
All No-cancer	7.854	4.157	41	0 to 16

Table 7. Summary MANOVA Tables for Dominance Scores

Source	SS	df	MS	F	P	r
Sex	156.360	1	156.360	10.719	0.002	0.336
Age	118.014	1	118.014	8.090	0.006	0.291
Cancer	5.378	1	5.378	0.369	0.546	0.062
Sex x Age	1.484	1	1.484	0.102	0.751	0.033
Sex x Cancer	0.570	1	0.570	0.039	0.844	0.020
Age x Cancer	21.258	1	21.258	1.457	0.231	0.124
Sex x Age x Cancer	41.068	1	41.068	2.815	0.098	0.172
Unexplained	1079.419	74	14.587			
Total	1386.939	81				

complete absence of interaction effects on dominance and the significant main effects of both sex and age leads to the conclusion that dominance scores are the simple addition of a dominance score representing the age effect and a dominance score representing the sex effect.

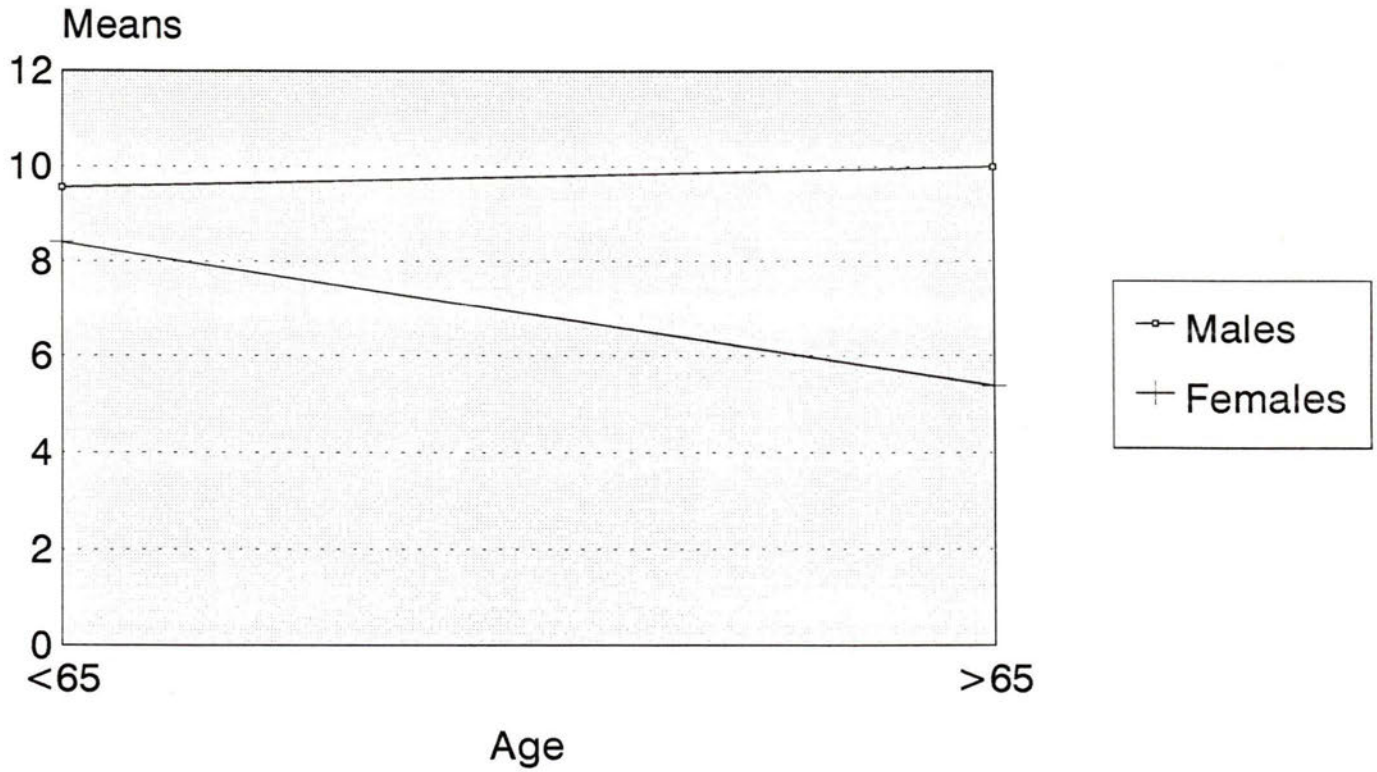
Men and women who have cancer and are 65 and under show a difference in dominance levels (9.56 and 8.4 respectively). Younger and older men had dominance scores that were fairly similar (9.56 $\leq$65 and 10. >65). On the other hand, younger women have higher scores (8.4) than older women (5.37). Older men (10.0) have higher scores than older women (5.37). These results for the cancer group showed dominance scores across the board that were higher for men than women (see Figure 2).

The mean level of dominance for healthy men 65 and younger was higher (11.67) than for healthy women of the same age (7.67). Younger men had higher (11.67) dominance scores than older men (6.67). Younger women had higher (7.67) dominance scores than older women (5.25). Older men had higher (6.67) scores than older women (5.25). These results for the healthy group showed dominance scores with a mean score that was higher (9.167) for men than for women (6.826). However, women under 65 had a higher score (7.67) than men (6.67) over 65 (see Figure 3).

Need-for-Approval

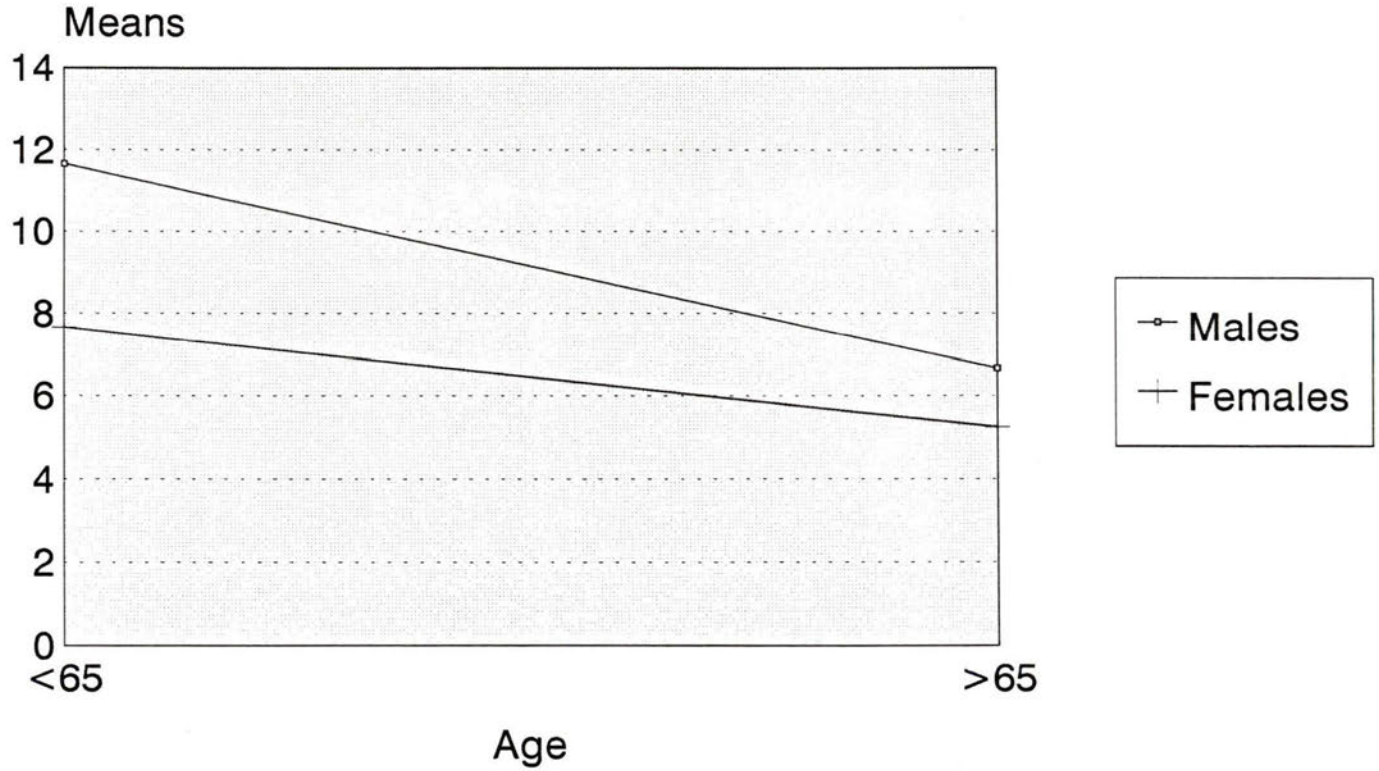
From the MANOVA tables there was a significant main

Figure 2



Means for Dominance as a Function of Age by sex for the Cancer group

Figure 3



Means for Dominance as a Function of Age by Sex for the No-cancer Group

effect of sex on the adapted Marlowe-Crowne scores, F (1, 74) = 5.725, p. <.05. But, there were no significant main effects for age or cancer state on these scores. Further, there were no significant two-way interactions of sex with age, or sex with cancer. However, there was a significant two-way interaction of age with cancer on need-for-approval, F (1, 74) = 5.064, p. <.05. There was not a significant three-way interaction of sex with age with cancer on need-for-approval (see Tables 3 and 8). Marlowe-Crowne scores are therefore, composed of a sex based component and an age/cancer interaction component. This would indicate that norming studies for Marlowe-Crowne should be aware of the interaction when considering age based norming tables.

As illustrated in Figure 4, in the cancer group both men and women in the over 65 groups have higher need-for-approval scores than do younger men and women (men, 65 and under, 14.67 to over 65, 20.22; women, 65 and under, 17.40 to over 65, 21.63), F (1,37) = 7.296, p. <.05 (see Table 9). Women in the cancer group score higher on the average than men (women 18.87, men 17.44).

In the non-cancer group there was a sex effect in the need-for-approval scores, F (1,37) = 4.994, p. <.05 (see Table 10). It appears that women (20.67) have a greater need-for-approval than do men (16.33) 65 years and under. Women (19.25) have a higher need-for-approval than men (16.78) over 65 as well. Men (16.78) over 65 have higher

Table 3

Descriptive Statistics for Marlowe-Crowne Scores

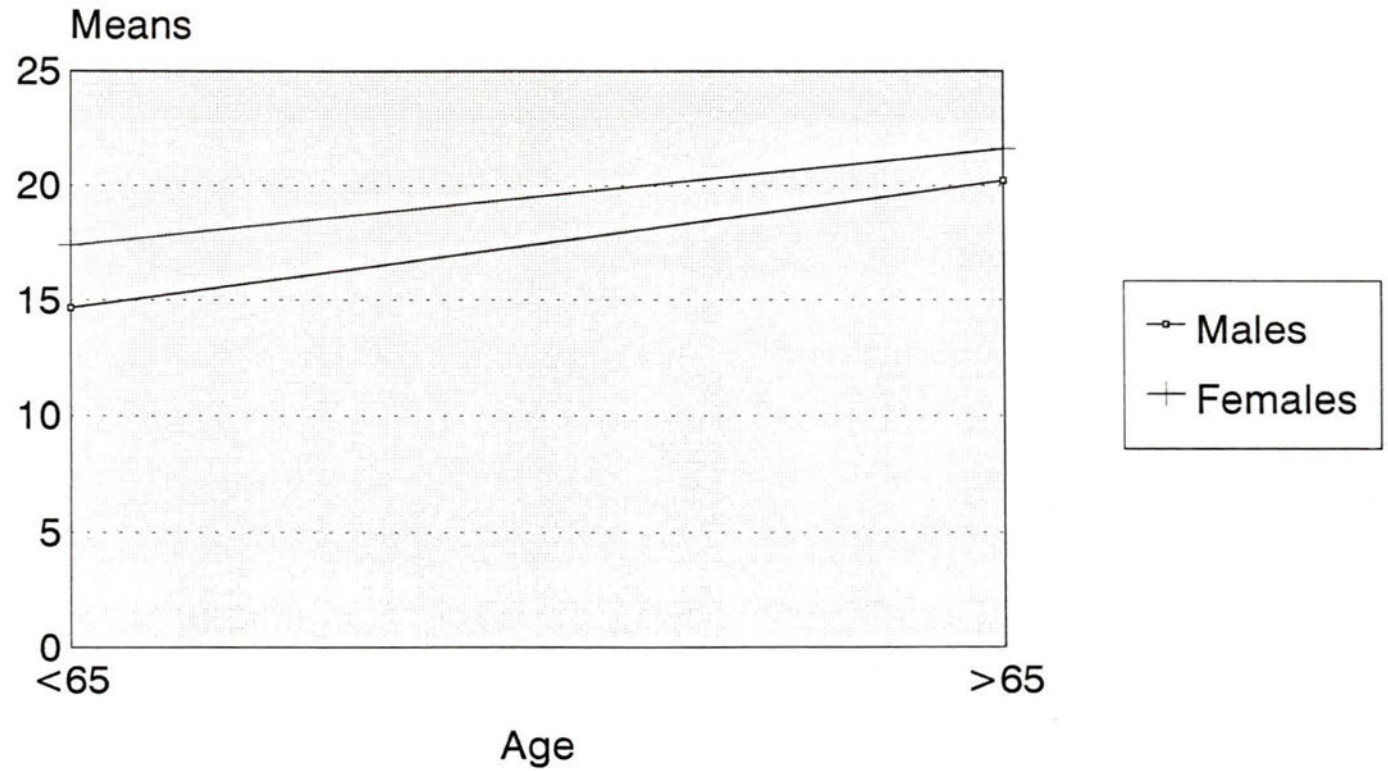
CANCER	Mean	Std. Dev.	N	Range
MALE				
65 & Under	14.667	4.822	9	9 to 23
Over 65	20.222	7.530	9	11 to 32
All Males	17.444	6.767	18	9 to 32
FEMALE				
65 & Under	17.400	4.641	15	10 to 25
Over 65	21.625	5.528	8	14 to 31
All Females	18.870	5.260	23	10 to 31
All Cancer	18.244	5.932	41	9 to 32

NON-CANCER	Mean	Std. Dev.	N	Range
MALE				
65 & Under	16.333	4.500	9	10 to 21
Over 65	16.778	4.658	9	9 to 22
All Males	16.556	4.449	18	9 to 22
FEMALE				
65 & Under	20.667	4.287	15	14 to 29
Over 65	19.250	6.756	8	7 to 26
All Females	20.174	5.167	23	7 to 29
All No-cancer	18.585	5.138	41	7 to 29

Table 8. Summary MANOVA Tables for Marlowe-Crowne Scores

Source	SS	df	MS	F	P	r
Sex	159.942	1	159.942	5.725	0.019	0.255
Age	89.268	1	89.268	3.195	0.078	0.190
Cancer	2.390	1	2.390	0.086	0.771	0.031
Sex x Age	12.306	1	12.306	0.440	0.509	0.071
Sex x Cancer	9.282	1	9.282	0.332	0.566	0.061
Age x Cancer	141.468	1	141.468	5.064	0.027	0.240
Sex x Age x Cancer	0.340	1	0.340	0.012	0.912	0.017
Unexplained	2067.419	74	27.938			
Total	2465.902	81	30.443			

Figure 4



Means for Marlowe-Crowne as a Function of Age and Sex for the Cancer Group

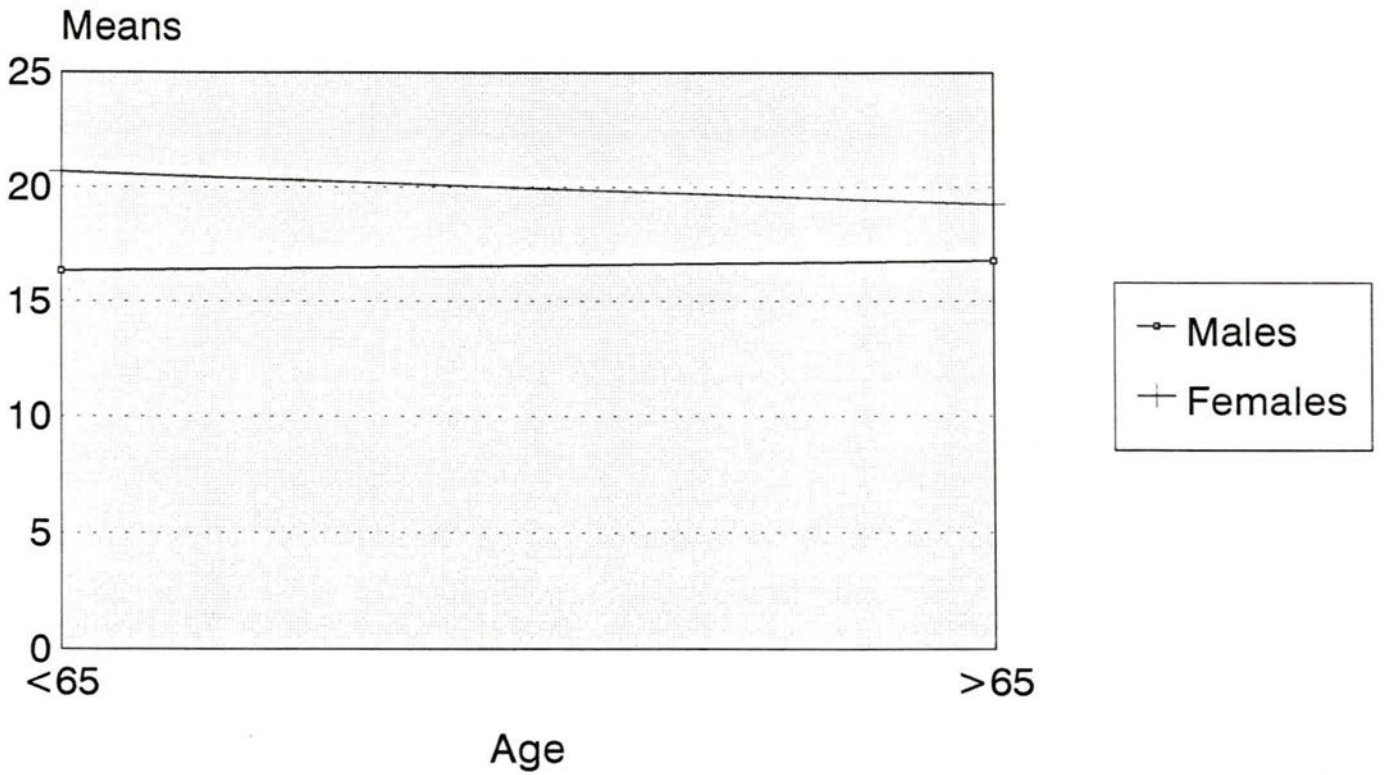
Table 9. Summary ANOVA Tables for Marlowe-Crowne Scores for Cancer Group

Source	SS	df	MS	F	P	r
Sex	46.082	1	46.082	1.476	0.232	0.180
Age	227.745	1	227.745	7.296	0.010	0.402
Sex x Age	4.277	1	4.277	0.137	0.713	0.055
Unexplained	1155.031	37	31.217			
Total	1407.561	40				

Table 10. Summary ANOVA Tables for Marlowe-Crowne Scores for Non-Cancer Group

Source	SS	df	MS	F	P	r
Sex	123.142	1	123.142	4.994	0.032	0.341
Age	2.991	1	2.991	0.121	0.730	0.053
Sex x Age	8.369	1	8.369	0.339	0.564	0.089
Unexplained	912.389	37	24.659			
Total	1055.951	40				

Figure 5



Means for Marlowe-Crowne as a Function of Age and Sex for the No-cancer Group

scores than men (16.33) 65 and under. Women (19.25) over 65 have lower scores than women (20.67) 65 and under (see Figure 5). The trend therefore, is opposite for the sexes. Men have a higher need-for-approval, between under 65 and over 65, while women have a lower need-for-approval, between under 65 and over 65.

Inter-relationships

If dominance is indeed independent of abasement, then dominance scores should be uncorrelated with abasement scores. The Pearson Product Moment Correlation Coefficient for abasement and dominance was not statistically significant, $\underline{r}$ = -.1956. Therefore, dominance is uncorrelated with abasement.

As stated in the introduction of this study, Marlowe-Crowne's need-for-approval seems clinically similar to abasement yet separate as a personality trait. Indeed, the relationship between need-for-approval scores and abasement scores produced a positive or direct but very weak correlation coefficient, $\underline{r}$ = .0333. Therefore, need-for-approval and abasement may seem conceptually similar in some way, but they were independent of each other in this study. The similarities may be due to their effect on a third underlying factor combining both traits.

As was true for the traits of abasement and dominance, the relationship between need-for-approval and dominance is

inverse and very weak, r = -.0137, supporting the conclusion that need-for-approval and dominance are uncorrelated.

Discussion

I would infer that the reason why the abasement scores were not greater between non-cancer and cancer groups for men over 65, and for women 65 and younger was because these two groups did not succumb to their abasement behaviours. Instead, they fought back and in the process became more dominant. Certainly, the mean dominance scores for these two groups were higher. Men over 65 had a higher dominance score (6.667 no cancer to 10.0 cancer), as did women 65 and younger (7.667 no cancer to 8.4 cancer). From my clinical observations it appeared that long-term survivors (5-20 years post diagnosis) were more dominant rather than abasive in their behaviour. For example, the long-term survivors in my clinical practice were more likely to express their own needs and work towards getting those needs met, rather than putting their needs aside as an abased person would have done.

I found it interesting to observe that 17 of the 41 (41.5%) subjects with a cancer diagnosis were long-term survivors. The long-term survivors for the cancer group were comprised of 47% women age 40 to 65; 23.5% women age 66 to 85; 12% men age 40 to 65; and 17.6% men 66 to 85. In this study women were twice as likely to be long-term cancer survivors than men. Women 40 to 65 years of age were four times more

likely to become long-term survivors than their male counterparts.

"Personality traits can change over time," states Douglas Jackson, "some older people tend to get more demanding for example, in their helplessness" (Interview held July 31, 1992 at Western University, London, Ontario). However, abasement and dominance were not correlated, therefore dominance could not have been compensatory for abasement behaviours for the long-term cancer survivors in this study. However, dominance was the only dimension representing a potentially forceful or aggressive trait in this study's questionnaire. The hypothesis that people with cancer may sometimes compensate for their abasement behaviours by becoming dominant is worthy of future research. The higher abasement scores for men 65 and younger, and women over 65 in the cancer group suggested that the disease of cancer does not make all of us into fighters; one does not always rise to the challenge. Instead abasement behaviours may become more intense as we encounter cancer.

Chapter Five

Discussion

This study provides support for the idea that the personality traits of self-abasement and need-for-approval (adapted from Marlowe-Crowne, 1964) are dynamically interrelated with the disease of cancer. The results of this study would suggest that the abasement trait interacts with age and sex in its association with the cancer state.

On the other hand, the levels of need-for-approval are not dependent on the interactive combination of age, sex, and cancer state, but are related to the effect of sex and the interaction effect of age with cancer state. These results indicate that a therapeutic approach focusing on self-abasement and need-for-approval cannot be employed in a uniform fashion for the 40 to 85 year old male and female adults of this study, with a cancer diagnosis. In other words, not all men and women, in this age group, with cancer will have high abasement scores or the same need-for-approval.

While replications of this study and a larger more random sample would contribute to more conclusive generalizations, some important implications can be drawn from these results. When working with adults with cancer, a therapist interested in the association of this illness with abasement should also consider the client's age and sex before planning treatment, due to the interaction among abasement scores and age, sex,

and cancer state. It may indeed be true that abasement scores are low for women 40 to 65 years and men over 65, but a therapeutic treatment that assumes high abasement scores would likely frustrate and patronize these individuals. Conversely, abasement scores were high for men 40 to 65 and women over 65. Thus therapeutic treatment focusing on low abasement scores would not address the needs of both groups. According to the results of this research, there will always be a strong, dependent interplay of variables to be considered which indicates that a blanket therapeutic treatment approach to these individuals is inappropriate to their needs.

In order to accurately assess need-for-approval, a therapist must be aware of a major relationship with the client's sex. This baseline effect provided by sex is augmented by an interrelated effect of age and cancer state. I would infer that the therapist must consider that in order to obtain an objective evaluation of the ongoing results of a client's therapy, it is necessary to evaluate the client's responses as valid or fulfilling the client's need-for-approval. For example, a therapist treating a man over 65, not knowing the client's cancer state, would assume that the man would have a low-need-for-approval. This assumption would be correct for a non-cancer client. However, if the man over 65 had cancer the above assumption would likely be incorrect and could bias the therapist's judgement of treatment effectiveness. The cancer client's need-for-approval would

cause the client to respond in such a way as to meet the therapist's desire rather than as a reflection of the client's own true needs. The female 65 and under faces the exact reverse situation in that the non-cancer female has a higher level of need-for-approval, whereas, the female 65 and under who has cancer is likely to have lower need-for-approval scores. The therapist, in dealing with the woman with cancer would be pushing to get the "true"feelings of the client when in fact they have been present from the beginning. The predictable client reaction would be frustration with the therapist who would be perceived as not believing or understanding the client's needs. It can be seen that because need-for-approval is an externally observable trait it is tempting to rely on our powers of observation when evaluating it. Clearly this would be a mistake, since the objectivity necessary to make such a judgement decreases with time spent in the therapeutic situation, but time is essential in order to accurately judge levels of need-for-approval. This would support an inference of the procedure of testing for need-for-approval before beginning the active therapy sessions.

In summary, I have three main inferences. Because need-for-approval is an externally observable behaviour trait and abasement is an internal or unobservable behaviour trait, it is important to recognize the different consequences associated with each. An evaluation of need-for-approval is necessary in order for the therapist to judge the

effectiveness of treatment. An evaluation of abasement is necessary to determine the quality of life for the client.

Sex and age provide direct relationships to dominance. There is no discernible relationship between dominance and cancer. This study shows the standard results for dominance due to age and sex; males have higher dominance scores than females, those under 65 have higher dominance scores than those over 65, except in the case of men with cancer where the scores are about equal. While there are indications that cancer may contribute to a change in dominance within the group of men aged over 65, the effect is not statistically significant. For the therapist, there is no need to take special interest in the dominance level prior to beginning therapy since it is not altered from the normal expectation of the therapist based on the client's age and sex.

I support Grossarth-Maticek's et al. (1982) assumption that sex and age along with psychological factors "have interacting effects on carcinogenesis" (p. 287). Even though I am not researching causation of cancer here, the variables of sex and age seem inextricably tied to quality of life and ability to cope with cancer, especially on a long-term basis as occurs today. Thus, sex and age were potential extraneous variables causing confounding in my study. However, confounding due to sex and age was not present in my study, because I treated sex and age as independent variables rather than permitting them to act as uncontrolled variables, by

closely matching sex and age. The two matched groups design that I used allowed for the formation of groups that were comparable on health state as long as the potentially extraneous variables of sex and age were matched across the cancer and no-cancer groups.

Confounding was also minimized by matching for other extraneous variables such as socioeconomic status, effect of cancer diagnosis on the dependent variables, and emotional crises states. Further, other diseases were controlled for by using a diverse referral source for both cancer and no-cancer subjects. Education level was not controlled for in either group. The relationship between knowledge about an illness and the ability to cope with it is still relatively sparse. The effect that the disease of cancer itself had on the dependent variable took effect over six months or more. Some subjects were undergoing treatment for cancer at the same time as they were participating in this study. Educational level and cancer treatment effect are both extraneous variables confounding the results of this study. Future research should consider a measure-remeasure design using time blocks from diagnosis to several years and should also consider treatment types as a factor.

I conscientiously used the same wording to describe the study and the questionnaires when speaking with doctors or their staff and the subjects. All of the people involved except for myself, were blind to the variables being

researched until after their involvement in the study was completed. Without an exception, and as Dr. Jackson (1991 interview) predicted, subjects performed their role seriously. Testing was done in as quiet and undistractable an environment as possible. To the best of my knowledge, none of the participants were able to identify what was being researched. I believe that my own bias was kept to a minimum, that there was no foreknowledge by research participants of the variables researched, and that testing conditions were within Jackson's (1984) recommended parameters.

The sampling approach was kept as uniform as possible in that each physician referred a matched pair of cancer and no-cancer participants, thus using the same selection bias for each matched pair. Each doctor used the same exclusion criteria for the study, to choose and refer each matched pair. All 15 doctors, however, could have used criteria for referral that were different in some way from each other. Thus, the sampling method should have been relatively bias free, as the same judgements biased by my research criteria and each doctor's interest were used by each doctor for referral of each matched pair.

Random sampling was not done because not all doctors, nor all adults with cancer, in the city of Victoria had an equal opportunity to take part in the research. The 22 doctors who were approached represented approximately 8% of the total of family medical doctors in the city. Even though the 22 were

chosen by the flip of a coin, each had the right to refuse; in fact seven physicians did refuse to take part on the basis of lack of time. Not all of the patients with cancer were necessarily represented either, because the doctors relied on their memories which possibly were biased by those patients who had been seen most recently or during the four months when data was collected. Doctors did feel, however, that all of their patients with cancer who fitted the criteria, had been considered. The non-randomization selection effect was held as constant as possible across the 15 doctors who referred subjects representative of their practices, considering the fact that both doctor and potential volunteer participant had the right to refuse to take part. As a result of the non-randomization selection, generalization of these results to adults with cancer outside of this study was not possible.

As with all investigative studies, there were numerous environmental and situational variables which could not be controlled in a non-laboratory setting. Abasement or need-for-approval trait level scores may have been affected by any of these variables or even by some aspect of the health care system itself. Thus, future research may take any of these variables into consideration when attempting to replicate this research.

The results of this systematically researched effect of cancer on abasement, need-for-approval, and dominance in this study are valid. The internal validity of this study's design

applies to the samples used, and stems from more than adequate numbers of subjects, valid and reliable questionnaires, matched attribute variables, selection bias held to a constant, and the use of MANOVA to control for the experiment wise and per comparison error ratio for the three dependent variables. The solution to the majority of confound problems would have been to use a very large sample from the general population and to measure and re-measure over an extended period of time. Such a longitudinal study would provide the opportunity to obtain ongoing demographic and quality of life data which would provide baseline norming information for both healthy and ill subjects, across a broader spectrum of age groups. The work of Grossarth-Maticek et al. provides optimism that such a study could be undertaken and completed in a scientific and accurate manner.

In summary, the results of this study provide an understanding of the interaction between two personality factors, self-abasement and need-for-approval, with cancer. The inner emotional conflicts of self-abasement and need-for-approval should be recognized as separate traits and treated separately with enabling approaches. When acknowledging internal self-abasement patterning, both the adult with cancer and the therapist will need support in order to develop the confidence that their revelations will be met with approval from their respective therapist or supervisor. The inference here is that therapists identify self-abasement patterning as

ego-dystonic (Prodgers, 1991) because they need approval for their own abasement revelations. Acknowledgement of abasement patterning, which is probably contingent on receiving this approval, would seem to be a crucial step towards providing the support to the self-abasing client with a diagnosis of cancer.

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APPENDIX A

M-C Scale

Adapted for Use

Marlowe-Crowne Scale available from:

Marlowe, D., & Crowne, D. P. (1964). The approval motive: studies in evaluative dependence. New York: John Wiley & Sons, Inc.

APPENDIX B

PRF - FORM E

ADAPTED FOR USE

PRF-Form E

DIRECTIONS

On the following pages you will find a series of statements which one might use to describe oneself. Read each statement and decide whether or not it describes you. Then, please answer true or false in the space provided to the right of the question. If you agree with a statement or decide that it does describe you, answer TRUE. If you disagree with a statement or feel that it is not descriptive of you, answer FALSE. **Answer every statement** either true or false, even if you are not completely sure of your answer.

GO ON TO NEXT PAGE

PRF FORM E

1. I like to be the first to apologize after an argument. True___; False___
2. I feel confident when directing the activities of others. True___; False___
3. I would not consider myself successful unless other people thought I was. True___; False___
4. If I feel sick, I don't like to have friends or relatives fuss over me. True___; False___
5. There are many activities that I prefer to reading. True___; False___
6. I am quite able to make correct decisions on different questions. True___; False___
7. I would never call attention to any of my weaknesses. True___; False___
8. I would make a poor military leader. True___; False___
9. I will not go out of my way to behave in an approved manner. True___; False___
10. I would like to be married to a protective and sympathetic person. True___; False___
11. I like to read several books on one topic at the same time. True___; False___
12. I am never able to do things as well as I should. True___; False___
13. One of my good points is that I never mind when others make fun of me. True___; False___
14. I would like to be a judge. True___; False___
15. When I am doing something, I often worry about what other people will think. True___; False___
16. I prefer not being dependent on anyone for assistance. True___; False___
17. I would rather work in business than in science. True___; False___
18. My life is full of interesting activities. True___; False___
19. I don't like running errands for others, even my friends. True___; False___
20. I avoid positions of power over other people. True___; False___
21. I don't buy things just because my friends will like them. True___; False___
22. I try to share my burdens with someone who can help me. True___; False___
23. I am more at home in an intellectual discussion than in a discussion of sports. True___; False___
24. I believe people tell me lies any time it is to their advantage. True___; False___
25. I have often let others take credit for something I have done rather than be impolite about it. True___; False___
26. I try to control others rather than permit them to

control me True____; False____
27. I constantly try to make people think highly of me. True____; False____
28. The person I marry won't have to spend much time taking care of me. True____; False____
29. I tend to shy away from intellectual discussions. True____; False____
30. If someone gave me too much change, I would point it out. True____; False____
31. I would never allow someone to blame me for something which was not my fault. True____; False____
32. I don't like to have the responsibility for directing the work of others. True____; False____
33. If I have done something well, I don't bother to call it to other people's attention. True____; False____
34. I want to be sure someone will take care of me when I am old. True____; False____
35. I like magazines offering thoughtful discussions of politics and art. True____; False____
36. I would be willing to do something a little unfair to get something that was important to me. True____; False____
37. Several people have taken advantage of me but I always take it like a good sport. True____; False____
38. I would like to play a part in making laws. True____; False____
39. I am proud of those of my accomplishments which are recognized by others. True____; False____
40. I usually make decisions without consulting others. True____; False____
41. Serious books are of little use to me. True____; False____
42. I get along with people at parties quite well. True____; False____
43. I resent being punished. True____; False____
44. I have little interest in leading others. True____; False____
45. I don't care whether people praise me or not. True____; False____
46. I like to ask other people's opinions concerning my problems. True____; False____
47. I think I would enjoy studying most of my life so I could learn as many things as possible. True____; False____
48. I did many very bad things as a child. True____; False____
49. Sometimes I let people push me around so they can feel important. True____; False____

50. In an argument, I can usually win others over to my side. True____; False____
51. When I am dressing for a party, I look for something that will be liked by other guests. True____; False____
52. I prefer to face my problems by myself. True____; False____
53. I really don't know what is involved in any of the latest cultural developments. True____; False____

54. I am glad I grew up the way I did. True____; False____
55. If someone accidentally burned me with a cigarette I would certainly mention it to that person. True____; False____
56. I feel uneasy when I have to tell people what to do. True____; False____
57. It seems foolish to me to worry about my public image. True____; False____
58. If I ever think that I am in danger, my first reaction is to look for help from someone. True____; False____
59. I do almost as much reading on my own as I did for classes when I was in school. True____; False____
60. I often question whether life is worthwhile. True____; False____
61. When someone bumps into me in a crowd, I usually say I am sorry. True____; False____
62. The ability to be a leader is very important to me. True____; False____
63. Nothing would hurt me more than to have a bad reputation. True____; False____
64. When I was a child, I disliked it if one of my parents was always worrying about me. True____; False____
65. I seldom read extensively on any one subject. True____; False____
66. I am always prepared to do what is expected of me. True____; False____
67. I try not to let anyone else take credit for my work. True____; False____
68. Most community leaders do a better job than I could possibly do. True____; False____
69. I don't go out of my way to earn the high esteem of people I know. True____; False____
70. I like to be with people who take a protective attitude toward me. True____; False____
71. I would enjoy being a scientist who was studying the effects of the sun on our earth. True____; False____
72. My daily life includes many activities I dislike. True____; False____
73. When people try to make me feel important, I feel uncomfortable. True____; False____
74. I am quite effective in getting others to agree with me. True____; False____
75. My social standing is important to me. True____; False____
76. I would rather act on my own then have a superior help me. True____; False____
77. I would rather build something with my hands than try to develop scientific theories. True____; False____
78. I am one of the lucky people who could talk with my parents about my problems. True____; False____
79. I do not particularly enjoy being the object of someone's jokes. True____; False____
80. I am not very insistent in an argument. True____; False____
81. I don't care if my clothes are unstylish, as long as I like them. True____; False____
82. I usually tell others of my misfortunes because they might

be able to assist me. True____; False____
83. I have a great curiosity about many things. True____; False____
84. Many things make me feel uneasy. True____; False____
85. I remember my failures more easily than my successes. True____; False____
86. I would like to be an executive with power over others. True____; False____
87. The good opinion of one's friends is one of the chief rewards for living a good life. True____; False____
88. As a child, I disliked having to be dependent on other people. True____; False____
89. Studying the history of ideas has no appeal to me. True____; False____
90. I am careful to plan for my distant goals. True____; False____
91. When standing in line, I don't let other people get ahead of me. True____; False____
92. I would not want to have a job enforcing the law. True____; False____
93. I don't try to "keep up with the Joneses." True____; False____
94. I often seek other people's advice. True____; False____
95. When I was a child, I read almost every book in my house and often went to the library. True____; False____
96. I find it very difficult to concentrate. True____; False____

APPENDIX C

DESCRIPTION OF ABASEMENT: REFERRED TO AS SELF-ABASEMENT.

Authored by H.A. Murray, 1938, p. 161-164.
Researched by D.N. Jackson, 1984 in PRF-Form E,
See Appendix B herein

Abasement

Desires and Effects: To submit passively to external force. To accept injury, blame, criticism, punishment. To surrender. To become resigned to fate. To admit inferiority, error, wrong-doing or defeat. To confess and atone. To blame, belittle or mutilate the self. To seek and enjoy pain, punishment, illness and misfortune.

Abasement is perhaps always a sub-need, but because of its general importance it is given a separate status.

Feelings and Emotions: Resignation or aboulia. Shame, guilt, remorse or contrition. Inferiority or humility. Helplessness or despair.

Trait-names and Attitudes: (a) Abasive, submissive, acquiescent, pliant, meek, humble, servile; (b) impotent, passive, patient, resigned; (c) contrite, penitent, prostrate; (d) timorous, weak, cowardly.

Press: Aggression and Dominance.

Actions: General: To adopt a passive, meek, humble, or servile attitude. To stand aside, take a back seat, let others push by and have the best. To submit to coercion and domination without rebellion or complaint. To allow oneself to be 'talked down.' To accept censure without rebuttal. To allow oneself to be bullied, dispossessed of objects. To receive physical injuries without retaliation.

Surrender: to 'give in,' to acknowledge defeat.

Renunciation: To give up material objects, or narcistic aims. To resign in favour of another object.

Penitence: Self-blame, self-accusation.

Atonement: To do something to balance a wrong. To expiate or atone for a sin by humiliating oneself. To wear sack-cloth and ashes. Under this may be classed many self-mutilations, self-inflicted illnesses and suicides.

Statements in Questionnaire

1. I am seldom able to hold up my end in a fight.
2. When something goes wrong I am more apt to blame myself than to blame the other fellow.
3. There are times when I act like a coward.
4. I am more apt to give in than to continue a fight.
5. My friends think I am too humble.
6. I feel nervous and anxious in the presence of superiors.
7. I am rather submissive and apologetic when I have done wrong.
8. I am shy and inhibited in my relations with women.
9. I am sometimes depressed by feelings of my own unworthiness.
10. feel that I must suffer before I can achieve my purpose.

Sentiments of Abasement

1. A man who knows that he is a fool is not a great fool.
2. The moral man does not desire anything outside of his position.
3. When Heaven is about to confer a great office on anyman, it first disciplines his mind with suffering.

4. Do little things as though they were great things and you will live to do great things as though they were little things.
5. There is nothing which the body suffers which the soul may profit by.
6. There is no man living who would willingly be deprived of his right to suffer pain for that is his right to be a man.
7. Charity should begin with your enemies.
8. Meekness is better than vengeance.
9. Render good for bad; blessings for curses.
10. Perhaps the only true dignity of man is his capacity to despise himself.
11. 'Tis vain to quarrel with our destiny.
12. The first step to self-knowledge is self-distrust.
13. All fortune is to be conquered by bearing it.
14. The life of no man is free from struggle and suffering.
15. If you wish to mount the ladder you must begin at the lowest rung.

APPENDIX D

LETTER TO DOCTORS

DESCRIPTION OF STUDY (TAKE HOME)

CONSENT FORM

Date

Dear Dr._____,

First of all, thank you for requesting more information about my current research. Briefly, I will let you know about my research. My name is Marion Ellis and I am an experienced psychotherapist in town who has gained the approval of the ethics committee of the University of Victoria to complete research for my master's degree in counselling psychology. My project number is 127-91.

In my work with adults with cancer, I have repeatedly observed particular characteristics which I am intent on studying. By use of two short questionnaires which are both reliable and valid, I wish to determine whether or not these traits are a genuine part of what those with a cancer must struggle in their lives.

What I need is your help by referring participants to me whom you feel would be willing to complete these questionnaires which will take approximately 20 minutes to one-half hour to complete. The following criteria are given to guide your choice of subjects:

- men and women under and over 65 with a diagnosis of cancer (not skin cancer)
- participants with cancer must be six months or more post diagnosis or date of relapse
- adults considered to be healthy, matched for sex and age range within approximately five years of the person with cancer already referred by you

The following constitute exclusion criteria:

- Brain tumour
- Skin cancer (melanomas are within the criteria)
- In-patient psychiatric history
- Mental Retardation
- H.I.V. Virus or A.I.D.S.
- No other major illness diagnosed

My deadline for completion of data collection is May 30th, 1992, and I would greatly appreciate any referrals before that date.

I trust this information will help you in referring participants. I am very appreciative of your assistance with my research and would be happy to discuss this further with you if you have any questions. Thank you.

Sincerely,

Marion Ellis,
Therapist,
M.A. Candidate
Phone #

APPENDIX D

Description of Study
(Take Home)

I have special education and training in bodymind therapy, I'm a nurse, a social worker with a degree and I am now working on my Master's degree in counselling at the University of Victoria. The study I am conducting is in the area of Health Psychology. The relationship between characteristics of being human and illness has been misunderstood by all of us for a long time. This study will add to a comprehensive picture of how medicine and an understanding of the whole person and wellness can and does interrelate.

This study has come out of ten years of counselling work with ll0 adults who have had cancer, and have wanted to do therapeutic work with the hope of affecting their disease. All of my clients have helped me to understand more and more clearly how illness in the body is a signal to the mind that something is out of balance. Illness then draws attention to this imbalance and then something can be done to help. From these experiences has come an interest in the interrelationship between body and mind, illness and healing, reveals itself. This revelation I believe, brings the possibility of ease and perhaps even healing. Many researchers, as have I are now helping people prolong their lives with counselling.

In this research I would like to ask if you would consider helping me test whether or not a human characteristic that my clients and I have discovered together is an important factor in this work or not.

If you wish to take part in the study you will be asked to complete two measures of normal personality functioning. I think these measures may have some relationship to your current situation. These tests will take thirty to forty minutes to complete but I feel they are purposeful. I ask that you give your undivided attention to their completion.

I also want you to know that your involvement in the study is completely voluntary, and your participation is not a requirement or expectation of your physician(s) or of the university. You may withdraw from the study at any time without unfavourable consequence.

Your participation in the study will be kept in strictest confidence. In order to ensure this, resulting test information will not include any information that will reveal your identity such as your name, your address or your age. A code number will be used instead of your name and after the completion of the study the code book will be destroyed so that there will be no trace to you.

You will be given a description of the full purpose of the study as well as the opportunity to share your personal reactions to the project, after your involvement is complete.

If you would like to obtain more information please contact me by message in Victoria at l-727-0543 (8:30 to 4:30, weekdays) and I will return your call.

Thank you for your attention to this information.

Marion Ellis

CONSENT FORM

I, _____, consent to being part of a study in health psychology which is being conducted by Marion Ellis.

I am aware that I will be completing two measures of normal personality functioning in a quiet room in my home or in a room supplied by the researcher in the presence of the researcher and possibly other participants. My time in this room will be kept private and uninterrupted. I understand that my involvement in the study will be kept in strictest confidence. In order to ensure this, resulting information will not include any information that will reveal my identity such as my name, my doctor's name, my address, etc.

I am aware that my participation in this study is completely voluntary, and that my participation is not a requirement or expectation of my physician(s) or of the university. I understand that I may withdraw from the study at any time without unfavourable obligation.

I further understand that if I experience any negative effects as a result of my involvement in this project, the researcher will willingly assist me in seeking professional counselling or other appropriate support. I may also debrief with the researcher after my involvement is complete.

Participant's Signature: _____

Date: _____

APPENDIX E

SCORING

The Marlowe-Crowne scale was scored using "X's" to identify need-for-approval within the response to the questions. Marlowe-Crowne's total number of questions were reduced by one, from thirty-three to thirty-two, due to a significant typographical error found only after the data was collected.

The erroneous number of thirty-three read:

"I have deliberately said something that hurt someone's feelings."

The correct version should have read:

"I have never deliberately said something that hurt someone's feelings."

The effect of this error on the results was negligible since I did not use any of the pre-existing normative data. A control was established by matching for the predominant factors of age and sex.

The adapted PRF-Form E was scored by using short forms which measured responses in the following categories:

Eg. Abasement was identified by Ab

Dominance was identified by Do

Social Recognition was identified by Sr

Succorance was identified by Su

Understanding was identified by Un

Desirability was identified by Dy

The short form was written in the appropriate true or false answer that measures for that trait and tallied by trait.

M-C Scale

For scoring of Marlowe-Crowne Scale see:

Marlowe, D., & Crowne, D. P. (1964). The approval motive: studies in evaluative dependence. New York: John Wiley & Sons, Inc.

PRF-Form E

DIRECTIONS

On the following pages you will find a series of statements which one might use to describe oneself. Read each statement and decide whether or not it describes you. Then, please answer true or false in the space provided to the right of the question. If you agree with a statement or decide that it does describe you, answer TRUE. If you disagree with a statement or feel that it is not descriptive of you, answer FALSE. **Answer every statement** either true or false, even if you are not completely sure of your answer.

GO ON TO NEXT PAGE

1. I like to be the first to apologize after an argument. True Ab False____

2. I feel confident when directing the activities of others. True Do False____

3. I would not consider myself successful unless other people thought I was. True Sr False____

4. If I feel sick, I don't like to have friends or relatives fuss over me. True____ False Su

5. There are many activities that I prefer to reading. True____ False Un

6. I am quite able to make correct decisions on different questions. True Dy False____

7. I would never call attention to any of my weaknesses. True____ False Ab

8. I would make a poor military leader. True____ False Do

9. I will not go out of my way to behave in an approved manner. True____ False Sr

10. I would like to be married to a protective and sympathetic person. True Su False____

11. I like to read several books on one topic at the same time True Un False____

12. I am never able to do things as well as I should. True____ False Dy

13. One of my good points is that I never mind when others make fun of me. True Ab False____

14. I would like to be a judge. True Do False____

15. When I am doing something, I often worry about what other people will think. True Sr False____

16. I prefer not being dependent on anyone for assistance. True____ False Su

17. I would rather work in business than in science. True____ False Un

18. My life is full of interesting activities. True Dy False____

19. I don't like running errands for others, even my friends. True____ False Ab

20. I avoid positions of power over other people. True____ False Do

21. I don't buy things just because my friends will like them. True____ False Sr

22. I try to share my burdens with someone who can help me True Su False____

23. I am more at home in an intellectual discussion than in a discussion of sports. True Un False____

24. I believe people tell me lies any time it is to their advantage. True____ False Dy

25. I have often let others take credit for something I have done rather than be impolite about it. True Ab False____

26. I try to control others rather than permit them to control me True Do False____

27. I constantly try to make people think highly of me. True Sr False____

28. The person I marry won't have to spend much time taking care of me. True____ False Su

29. I tend to shy away from intellectual discussions. True____ False Un

30. If someone gave me too much change, I would point it out. True Dy False____

31. I would never allow someone to blame me for something which was not my fault. True____ False Ab

32. I don't like to have the responsibility for directing the work of others. True____ False Do

33. If I have done something well, I don't bother to call it to other people's attention. True____ False Sr

34. I want to be sure someone will take care of me when I am old. True Su False____

35. I like magazines offering thoughtful discussions of

politics and art. True Un False___

36. I would be willing to do something a little unfair to get something that was important to me. True___ False Dy

37. Several people have taken advantage of me but I always take it like a good sport. True Ab False___

38. I would like to play a part in making laws. True Do False___

39. I am proud of those of my accomplishments which are recognized by others. True Sr False___

40. I usually make decisions without consulting others. True___ False Su

41. Serious books are of little use to me. True___ False Un

42. I get along with people at parties quite well. True Dy False___

43. I resent being punished. True___ False Ab

44. I have little interest in leading others. True___ False Do

45. I don't care whether people praise me or not. True___ False Sr

46. I like to ask other people's opinions concerning my problems. True Su False___

47. I think I would enjoy studying most of my life so I could learn as many things as possible. True Un False___

48. I did many very bad things as a child. True___ False Dy

49. Sometimes I let people push me around so they can feel important. True Ab False___

50. In an argument, I can usually win others over to my side. True Do False___

51. When I am dressing for a party, I look for something that will be liked by other guests. True Sr False___

52. I prefer to face my problems by myself. True___ False Su

53. I really don't know what is involved in any of the latest cultural developments. True___ False Un

54. I am glad I grew up the way I did. True Dy False___

55. If someone accidentally burned me with a cigarette I would certainly mention it to that person. True___ False Ab

56. I feel uneasy when I have to tell people what to do. True___ False Do

57. It seems foolish to me to worry about my public image. True___ False Sr

58. If I ever think that I am in danger, my first reaction is to look for help from someone. True Su False___

59. I do almost as much reading on my own as I did for classes when I was in school. True Un False___

60. I often question whether life is worthwhile. True___ False Dy

61. When someone bumps into me in a crowd, I usually say I am sorry. True Ab False___

62. The ability to be a leader is very important to me. True Do False___

63. Nothing would hurt me more than to have a bad reputation. True Sr False___

64. When I was a child, I disliked it if one of my parents was always worrying about me. True___ False Su

65. I seldom read extensively on any one subject. True___ False Un

66. I am always prepared to do what is expected of me. True Dy False___

67. I try not to let anyone else take credit for my work. True___ False Ab

68. Most community leaders do a better job than I could possibly do. True___ False Do

69. I don't go out of my way to earn the high esteem of people I know. True___ False Sr

70. I like to be with people who take a protective attitude toward me. True Su False____

71. I would enjoy being a scientist who was studying the effects of the sun on our earth. True Un False____

72. My daily life includes many activities I dislike. True____ False Dy

73. When people try to make me feel important, I feel uncomfortable. True Ab False____

74. I am quite effective in getting others to agree with me. True Do False____

75. My social standing is important to me. True Sr False____

76. I would rather act on my own then have a superior help me. True____ False Su

77. I would rather build something with my hands than try to develop scientific theories. True____ False Un

78. I am one of the lucky people who could talk with my parents about my problems. True Dy False____

79. I do not particularly enjoy being the object of someone's jokes. True____ False Ab

80. I am not very insistent in an argument. True____ False Do

81. I don't care if my clothes are unstylish, as long as I like them. True____ False Sr

82. I usually tell others of my misfortunes because they might be able to assist me. True Su False____

83. I have a great curiosity about many things. True Un False____

84. Many things make me feel uneasy. True____ False Dy

85. I remember my failures more easily than my successes. True Ab False____

86. I would like to be an executive with power over others. True Do False____

87. The good opinion of one's friends is one of the chief rewards for living a good life. True Sr False____

88. As a child, I disliked having to be dependent on other people. True____ False Su

89. Studying the history of ideas has no appeal to me. True____ False Un

90. I am careful to plan for my distant goals. True Dy False____

91. When standing in line, I don't let other people get ahead of me. True____ False Ab

92. I would not want to have a job enforcing the law. True____ False Do

93. I don't try to "keep up with the Joneses." True____ False Sr

94. I often seek other people's advice. True Su False____

95. When I was a child, I read almost every book in my house and often went to the library. True Un False____

96. I find it very difficult to concentrate. True____ False Dy

VITA

Surname: Ellis Given Names: Marion Jeanne

Place of Birth: Brantford, Ontario Date of Birth: Feb. 25, 1949

Educational Institutions Attended;

University of Victoria	1985-1993
University of Western Ontario	1973-1976
Hamilton Civic Hospital, School of Nursing	1968-1970

Degrees Awarded:

B.S.W.	University of Western Ontario	1976

Other Formal Education:

Therapist of Bioenergetic Analysis	1986
Registered Nurse	1970

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Title of Thesis Self-abasement as it Relates to Cancers in Men and Women

Author [redacted]
(Signature)

MARION J. ELLIS
(Name in Block Letters)

April 30, 1993
(Date)