



THE INVESTIGATION OF NEGATIVE CAUSAL ATTRIBUTIONS AND THEIR RELATION WITH THE SOCIAL SUPPORT FOR THE CANCER PATIENTS: A TEST OF THE HELPLESSNESS THEORY

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Abstract

The paper addresses the issue of causal attributions in the evolution of depression. We suggest an investigation of the negative causal attributions and their relation with the social support, solitude, self-esteem and satisfaction with life, in the presence of psychiatric comorbidity for cancer patients. Several predictor variables were accounted for in a multifactor design in which the criterion variable was the level of depression. The study contributes to the enhancement and application of learned helplessness theory in psycho-oncology and offers an inside view of the psychopathological mechanisms involved during the onset of the illness. Along the study we prove that the negative attributional patterns are activated in advanced stages of the disease hypothetically due to the perception of the lack of control on the disease; there is the possibility that, at latent level, the cognitive schema of helplessness to have once existed and to be activated together with the evolution of the disease.

Keywords: helplessness, social support, satisfaction with life, loneliness, cancer, depression

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Introduction

Depression increases along with the apparition of metastases, along with relapses, with the progression of cancer or when diagnostic intervenes at less than one month since the evaluation.

Starting from the studies regarding the despondency, we could do some predictions on cancer, but still in the studies where MMPI and Rorschach were used has not been found any correlation of despondency with cancer. Consequently, Eysenck (1994) considers that in many studies, the instruments used are irrelevant for the proposed purpose and were not designated for testing a specific theory and they are applied to wrongly chosen groups. If an adequate instrument is used one can obtain high levels of prediction.

The helplessness and hopelessness constructs have been identified along the time as being factors in the development of cancer. Epidemiological studies failed in their attempt for finding a growth of cancer incidence within the depressive population. Levy (1984, p. 14) shows that in the case of women with breast cancer a significant relation can be found between premature death, the helplessness attitudes and stoicism, in contrast with those expressing the fighting spirit or negation. These answers are much more predictive for survival than the stage of the disease in the basic treatment.

Theoreticians of learned helplessness consider that doctors should see patients as collaborators in their treatment, in this manner they would perceive adequately the on going situation and they would have the feeling of control. Laboratory experiments show that this work strategy would immediately affect the biological substratum of the disease.

Edelman and Kidman (1997) indicated that it was not the stress in itself but the attitudes of the individuals and the answers indicating the adjustment, the ones which could be related to cancer. Consequently, hopelessness, emotional repression, helplessness and depression are hypothetical factors which could influence the course of the disease.

Single persons are more predicted to develop cancer as they postpone medical consults and the beginning of treatment, having a lower survival rate after finding the diagnosis. Generally, married patients who are diagnosed with cancer survive more than the ones who are not married, the emotional support outside the relationship being associated with a better survival rate. In the case of some women, the marriage supposes an involvement in a

relationship meant to fulfil the other's needs rather than the own needs of the woman (Weisse, 1992; Salmon, 2000).

There are at least two reasons for which the social environment is important in the study of cancer. The first, elements of the social environment, promotes the state of well being and protects the person against the effects of the stressing life events. The second one, cancer, is a stressing event which influences the interpersonal relationships. As it is a potential fatal disease and is often characterised by a certain stigma, the members of the patients' net can draw back or can react inadequately. Cancer also affects relations indirectly, by restricting social activities which leads to a reduced inter-socialising. Patients diagnosed with cancer can have difficulties in obtaining social results especially when they need them most.

Baltrusch, Stangel, & Titze (1991, p. 316) claimed that everyday stress in connection with other psychosocial factors can determine the development and maintenance of cancer; divorce or defective conjugal relations can be associated with an increase of depression and a decrease of immunity answer in women's case. On the other side, at men the increase of mortality in cancer positively correlates with divorce, separation, isolation, unemployment and the lack of social support.

Stein, Linn, & Stein (1989) showed that patients who frequently feel isolated from their family and friends are more inclined to developed cancer or in the case of already diagnosed persons, the (sometimes) self imposed loneliness is associated with the relapse of the disease. Self esteem can be altered by cancer and mainly when it decreases as a consequence of stress or aversive consequences on health.

Berkman, Stolberg, Parker, & Stearns (1983, pp. 96-97) started from the idea according to which physical dysfunctions, mental and psychological factors, communitarian resources and social support influence the development of cancer at institutionalised persons. An important role was given especially to the social support and mainly to the spouse's support of the cancer diagnosed person. The lack of social support is associated with a rapid deterioration of the physical condition and implicitly with the aggravation of the disease.

Psycho-social factors have a modular effect on the course of the disease. Supportive social relations have a buffer effect, counter balancing the effects of the stress on immunity, owed to cancer, the result being the

reconstruction of immune mechanisms which are important in the resistance to cancer (Levy, Herberman, Sanzo, Lee, & Kirkood, 1990).

Individuals who are capable to develop close and satisfactory relations with other significant persons prove a better adjustment to the disease and treatment than those who do not have supportive relationships. Revenson, Wollman, & Felton (1983) showed that in the case of patients with advanced cancer, the emotional support and reinsurance are much more effective than medication in fighting depression and anxiety which come along with incurable diseases.

The study proposed renders evident the way in which the negative causal attributions and the disadaptive attribution style, together with the psychosocial characteristics of patients with cancer can be considered factors influencing the patient's condition along the disease and treatment.

Objective

We suggest an investigation of the negative causal attributions and their relation with the social support, solitude, self-esteem and satisfaction with life, in the presence of psychiatric comorbidity for cancer patients.

We start from the idea according to which at cancer diagnosed persons there is an intensification of disadaptive causal assignments which shall lead to chronic and pervasive deficits as compared to the patients with depression or healthy people. We consider that negative causal assignments shall determine or shall be associated with depressive symptomatology which shall lead to a comorbidity of cancer with depression.

Method

Participants diagnosed with cancer

120 patients diagnosed with cancer, aged between 36 and 70 years old ($m = 58,1$; $\sigma = 9,13$) were recruited from 3 clinics: Arad, Timișoara, and Oradea from Romania. The patients did not show symptoms of a brain storm that could affect their cognitive activity. Details of the pathology for every form of neoplasm, including the level and the type of malignancy and data about the previous surgical interventions were obtained from the doctors taking care exclusively of the patients.

The patients included in the study were 67 (55,8%) women and 53 (44,2%) men and they were classified as having the next stadiums of the disease: stadium I and II, 36 (30%) patients (out of which 23; 34,3% women and 13; 24,5% men), stadium III and IV, 84 (70%) patients (out of which 44; 65,7% women and 40; 75,5% men). From the point of view of the marital status the data is presented as follows: 14 (11,7%) unmarried, 79 (65,8%) married, 17 (14,2%) divorced and 10 (8,3%) widowers. From the point of view of the diagnosis, in the study were included 26 (21,7%) patients with ovarian and cervix cancer, 12 (10%) patients with breast cancer, 14 (11,7%) patients with renal and urinary bladder cancer, 35 (29,2%) patients with bronchopulmonary cancer, 33 (27,5%) patients with alimentary canal cancer.

Patients diagnosed with depression

The study included 79 patients diagnosed with depression and were hospitalized in neurological psychiatric hospitals in Bihor county, Romania. The participants' age ranged between 18 and 65 years old ($m = 38,08$; $\sigma = 14,79$). Likewise we specify that 34 men were included (43%) and 45 women (57%). From the point of view of the marital status, in the study were included 33 unmarried patients (41,8%), 41 married patients (51,9%), 4 divorced patients (5,1%) and 1 widower patient (1,3%).

Nonclinic participants

The participants randomized from the population ($N = 103$) were aged between 25 and 77 years ($m = 42,35$; $\sigma = 13,63$). 47 men (45,6%) and 56 women (54,4%) took part in the study. From the point of view of the marital status, 73 participants were married (70,9%), 26 unmarried (25,2%), 2 divorced (1,9%) and 2 widowers (1,9%).

Measures

Attributional Style Questionnaire (A.S.Q.) devised by Peterson, Semmel, von Baeyer, Abramson, Metalsky, & Seligman (1982); it is a measure of explanatory style patterns which in turn reflects one's tendency to select certain causal explanations for favorable or unfavorable events. The internal consistency reported by Marian (2010) was $\alpha = .82$ for positive events, and $\alpha = .72$ for negative events. This moderate internal consistency is supported by other findings.

Current Thoughts Scale (C.T.S.) devised by Heatherton & Polivy (1991); it consists of 20 items loaded on three factors: a. performance self-esteem, b. social self-esteem, and c. appearance self-esteem. This instrument was designed to assess one's thoughts at certain times. Marian (2009) reported a .84 alpha coefficient for this scale. The C.T.S. aims to uncover the real effect of the variance of self evaluations on thoughts, emotions and behavior.

Multidimensional Scale of Perceived Social Support (M.S.P.S.S.) devised by Zimet, Dahlem, Zimet, & Farley (1988); it consists of 12 items loaded on three factors: a. family, b. friends, and c. significant others. Each item is structured according to the three factors. Internal consistency is .91 (12 items). Test-retest trust quotient of the two testing phases (T₁ and T₂) is between .67 and .80 (Marian, 2006).

Satisfaction with Life Scale (S.L.S.) devised by Pavot & Diener (1993); it measures one's global satisfaction with life. The scale was not designed to measure satisfaction in specific domains such as health or financial status however it allows the subjects to integrate such issues in the global index. After a rigorous item analysis five items remained to which the subjects respond on a seven point Likert scale. The scale shows high internal consistency and temporal stability Marian (2007).

Differential Loneliness Scale (D.L.S.). Schmidt & Semart (1983) used Differential Loneliness Scale to measure the satisfaction / dissatisfaction degree related to the four specific social relations named romantic or sexual, friends, family relations and community relations. The internal consistency was .91 (20 items). Test-retest trust quotient of the two testing phases (T₁ and T₂) is between .51 and .91 (*apud* Marian, 2008).

Beck Depression Inventory. This is a self-report measure of affective, behavioral, cognitive, and somatic symptoms of depression. All participants completed the 13-item short form of the Beck Depression Inventory (B.D.I.; Beck & Beck, 1972). This self-report, multiple-choice instrument correlates highly with the longer version of the B.D.I. (*apud* Marian, 2008).

Procedure

Our purpose is to engage in this study the application of some patients' evaluation criteria according to diagnosis, the stage of the disease, functional status and the level of the depression.

We used the Quality of Life Scale (Q.L.S.) to realise a subjects' grouping on four levels of functional capacity.

The participants received the required instructions, so that the scales to be adequately filled in. The cancer patients received additional instructions by which we wanted them to report themselves to the ongoing condition, and according to it, to answer the questionnaires. Because of the restrictions imposed by the oncology clinics a second evaluation, which would have brought for sure extremely important additional data, wasn't possible. The evaluations weren't vertical and we could not estimate the rate of the deceases or of the surviving rate after the evaluation (many of the family members do not report the decease of the patient or other relevant data to the clinic).

Results and discussion

In the first phase of the research we maintained constantly the influence of the activity level of the cancer patient considering we could observe the differences between the negative attribution style and the loneliness concerning depression. We consider that the negative causal attributions linked to accomplishment, once achieved, influence significantly the way in which cancer patients shall react to negative events generating depressive symptoms.

Using ANCOVA we proposed ourselves to increase the power of negative acceleration of the independent variable (IV) effect: negative attributional style and loneliness on dependent variable (DV) depression at cancer patients. Consequently, the main effects and the interactions between the two factors are evaluated after the depression values were adjusted according to the values of the co-variable at the cancer patients' functioning level. In case IV- low negative attributional style, we identified 53 patients and 67 patients in the case of high negative attributional style. In the case IV – loneliness, there were identified 68 patients who obtained low scores being included in the non isolation group and 52 patients who isolated themselves.

The co-variable - level of functioning - presents a linear correlation with the depression $r = - .32$, $p < .01$ (Bonferroni correction indicating $p < .05$).

In table 1 it is observed the significant influence of the functioning level on depression [$F(1, 115) = 5,954$, $p < .01$] and of the two variables, the

negative attribution style [$F(1, 115) = 4,192, p < .04$] and the isolation [$F(1, 115) = 6,423, p < .01$] indicating hereby a main effect. We can state that the groups differ significantly with regards to depression even when the influence of the cancer patient's functioning level was „controlled”.

Table 1. Comparison of the depression level at cancer patients according to negative attributional style and loneliness, by using ANCOVA technique

Source	Sum squares	df	Mean square	F	Sig.	Effect size r^2
FL	207,28	1	207,28	5,954	,01	.05
NAS	145,93	1	145,93	4,192	,04	.03
L	223,61	1	223,61	6,423	,01	.05
NAS * L	82,46	1	82,46	2,369	,12	
Error	4003,44	115	34,81			
Total	20196,00	120				

Note 1: FL = Functional level; NAS = Negative attributional style; L = Loneliness

Note 2: $R^2 = .155$ ($R^2_{\text{adjusted}} = .126$)

We proposed ourselves to increase the revealing power of the IV effect (assignments related with realization at negative events and solitude) on DV depression. As a consequence, the main effects of the two factors, causal assignments related to accomplishment in the context of some negative life situations and solitude, are evaluated after the values of the depression had been adjusted according to the values of the co-variable functioning level of the cancer patient.

According to our presumption, by maintaining constant the influence of the degree or of the functioning level for the patients, there are significant differences between the two variables (accomplishment and solitude) regarding depression. We consider that negative causal assignments related to accomplishment (failure, negative reaction to the group and the impossibility for finishing an activity), once formed, they significantly influence the way in which cancer patients shall react to negative effects generating symptomatology of depressive type.

In case IV- reduced negative accomplishments, we identified 37 patients and in the case of highly negative accomplishments a number of 83 patients; in case IV- solitude, there was identified a number of 68 patients who

obtained low scores, being included in the non-isolation lot and a number of 52 patients who isolated themselves.

Table 2. Comparison of the depression level according to the assignments related to accomplishment and loneliness for the cancer patients by using ANCOVA technique

Source	Sum squares	df	Mean square	F	Sig.	Effect size r^2
FL	255,82	1	255,82	7,593	,007	,06
ASNAE	273,07	1	273,07	8,105	,005	,06
L	187,17	1	187,17	5,556	,02	,05
ASNAE * L	75,47	1	75,47	2,240	,13	
Error	3874,48	115	33,69			-
Total	20196,00	120				

Note 1: FL = Functional level; ASNAE = Attributional style for negative achievement events; L = Loneliness

Note 2: $R^2 = .182$ ($R^2_{\text{adjusted}} = .154$)

We observe the significant influence of the negative accomplishments level on depression [$F(1, 115) = 8,105, p < .01$] and on loneliness [$F(1, 115) = 5,556, p < .02$] by indicating a main effect (Table 2). The groups differ significantly with regards to depression even when the influence of the functioning level was maintained constant. [$F(1, 115) = 7,593, p < .01$]. The data obtained sustain our hypothesis in the way that the production of an outstanding life event and the assignment of negative realizations (such as failure, negative reaction to the group and the impossibility to finalize an activity) and the loneliness felt, maintain the disposition and/ or depressive symptomatology (even when the influence of the functioning level is constantly maintained) of cancer patients.

In the next stage, the patients were grouped according to the level of depression (154 non-depressive persons and 148 depressive persons) and its organization in three groups: the lot of the cancer patients ($N = 120$), the control lot ($N = 103$) and the depressive persons' lot ($N = 79$).

Consequently, we started from the presumption according to which by maintaining constant the influence of the satisfaction in life there are significant differences between the two variables, accomplishment and self appreciation generally, with regards to the functioning capacity.

Table 3. Comparison of the functioning level according to the attributions related to accomplishment and current thoughts about self at depressive cancer patients and the control lot by using ANCOVA technique

Group	Source	Sum squares	df	Mean square	F	Sig.	Effect size r^2	
(a) CG	ND	SL	,96	1	,96	,147	,70	-
		ASNAE	5,13	1	5,13	,783	,38	-
		CT	,16	1	,16	,024	,87	-
		ASNAE * CT	4,43	1	4,43	,676	,41	-
		Error	301,84	46	6,56			
		Total	308,98	50				
	D	SL	9,60	1	9,60	6,057	,01	.08
		ASNAE	13,55	1	13,55	8,550	,00	.11
		CT	,73	1	,73	,465	,49	-
		ASNAE * CT	7,40	1	7,40	4,669	,03	.06
		Error	101,48	64	1,58			
		Total	135,94	68				
(b) CoG	ND	SL	,005	1	,00	,002	,96	-
		ASNAE	,00	1	,00	,001	,97	-
		CT	,88	1	,88	,358	,55	-
		ASNAE * CT	,90	1	,90	,366	,54	-
		Error	241,94	98	2,46			
		Total	243,67	102				
(c) DG	D	SL	9,94	1	9,94	4,060	,04	.05
		ASNAE	3,34	1	3,34	1,366	,24	-
		CT	11,49	1	11,49	4,694	,03	.05
		ASNAE * CT	1,17	1	1,17	,481	,49	-
		Error	181,25	74	2,44			
		Total	199,72	78				

Note 1: CG = Cancer group; CoG = Control group; DG = Depression group; ND = Never depressed; D = Depressed; SL: Satisfaction with life; ASNAE = Attributional style for negative achievement events; CT = Current thoughts

Note 2: (a) $R^2 = ,023$ ($R^2_{\text{adjusted}} = -,062$); (b) $R^2 = ,253$ ($R^2_{\text{adjusted}} = ,207$); (c) $R^2 = ,007$ ($R^2_{\text{adjusted}} = -,033$); (d) $R^2 = ,092$ ($R^2_{\text{adjusted}} = ,043$)

In table 3 we can observe the influence of the satisfaction level at cancer patients who had high scores at BDI [$F(1, 64) = 6,057, p < .01$] and of the variable attribution negative style in situations which suppose the accomplishment [$F(1, 64) = 8,550, p < .01$] indicating a main effect. Being insignificant, the data obtained in the case of current thoughts about the self do

not indicate a direct effect, but still the interaction between the negative attributional style in situations supposing the accomplishment and the current thoughts about self is statistically significant [$F(1, 64) = 4,669, p < .03$]. Statistically, the groups differ significantly with regards to the functioning level, even when the influence of the satisfaction level in the life of the cancer patient, also presenting the symptomatology characteristic to depression, was „controlled”. The fact that the patient diagnosed with cancer appeals to a negative attributional style with regards to accomplishment, can be due to the fact that he admits the gravity of the disease and its finality, which leads to an evaluation of life, failures and of the impossibility to finalize the activities by determining a decrease of the functioning level.

In table 3 we present the size of the effect in the case of the life satisfaction for cancer patients and with high scores at BDI, $r^2 = .08$ indicates an effect over the average on the functioning level and similarly the size of the effect in the case of negative attributional style with regards to accomplishment $r^2 = .11$ indicates a significant effect (above the average). The effect is important from a practical point of view and it is statistically significant also considering the fact that there are no other researches to infirm these results.

In the following step of the research, the participants were selected according to the stage of the disease; hereby 36 cancer patients were considered in stage I and II and 84 cancer patients were considered in stage III and IV of the disease.

Thereby, by maintaining constant the influence of the patients` social support, there are statistical differences regarding the personal attributional style (the CPCN score out of ASQ) and the self appreciation generally, with regards to the functioning capacity. The values of the functioning level were adjusted according to the values of the social support co-variable of the cancer patients, evaluating in this manner the main effects of the two variables in the situation where all the patients would generally have the same social support.

In table 4 one can observe the influence of the social support perception on the functioning level in the case of the patients who are in stages III and IV of the disease [$F(1, 83) = 5,315, p < .02$]; also it can be observed the influence of the personal attribution style factor (score CPCN) [$F(1, 83) = 7,478, p < .01$] indicating a main effect in the case of the patients who are in the stages III and IV of the disease. The effect on the functioning level, only in the case of the patients from the stages III and IV, is represented by the way in which they

explain their current condition; hereby, there is a great probability that the negative explanatory style of the events to be perpetuated also in other circumstances of the patients` life. As we can notice, after the analysis of table 4, in the case of the cancer patients in stages I and II, the explanatory style is not a probable determinant factor also due to the fact that the coping mechanisms and the compliance to treatment are still active.

Table 4. Comparison of the functioning level according to the CPCN score and the current thoughts about self at the cancer patients in the stages I, II and III, IV by using ANCOVA technique

Stages illness	Source	Sum squares	df	Mean square	F	Sig.	Effect size r^2
Stages I and II	PSS	1,84	1	1,84	,747	,38	-
	CT	4,94	1	4,94	2,002	,15	-
	CPCN	2,08	1	2,08	,843	,36	-
	CT * CPCN	,13	1	,13	,055	,81	
	Error	153,86	31	4,96			
	Total	154,88	35				
Stages III and IV	PSS	18,62	1	18,62	5,315	,02	.06
	CT	3,01	1	3,01	,860	,35	-
	CPCN	26,19	1	26,19	7,478	,00	.08
	CT * CPCN	10,82	1	10,82	3,090	,08	
	Error	276,75	79	3,50			
	Total	318,81	83				

Note: PSS = Perceived social support; CT = Current thoughts; CPCN = composite positive explanatory style (CP) & composite negative explanatory style (CN)

The fact that the negative causal attribution mechanisms were not identified also in the case of the patients in stages I and II determines us to consider the hypothesis that they do not act only as distal factors but also as proximal factors with an important impact on the way in which the patient adjusts himself to different contexts of the existence.

Conclusions

Along the work we tried to relieve the implications of helplessness learned in terms of diathesis–stress in the case of specific causal assignments learned helplessness and hopelessness theory (Abramson, Alloy, & Metalsky,

1988; Metalsky & Joiner, 1992). The diathesis component is considered to be a form of negative emotionality which interacts with the stress in maintaining and in the evolution of the final effect of the mental or somatic disease (in our study, the cancer).

Edelman and Kidman (1997) indicated that both diathesis and the diathesis–stress effect are identical, the depression constituting both the diathesis and the effect. We consider that this problem is not actual when the effect is cancer, but we can argue that the effect can produce the diathesis invoked in the specific literature namely the cancer causes the depression and this perspective is sustained by our study.

Taking into account the pertinent observations of Morris, Pettingale, & Haybittle, (1992, p. 105) which indicated that the studies reported in the specific literature followed the replication of the previous studies, included different forms of cancer and submitted to a strict examination and evaluation the measurement methods practiced in the past, we tried to apply a still controversial but promising theory (learned helplessness theory) in the field of psycho-oncology and additionally to use the previously validated instruments.

The patients diagnosed with cancer are more depressive than the ones from the control lot but not compared to the patients diagnosed with clinical depression. Here arises the question of comorbidity and the presence of depression also before the diagnosis, being a factor which could amplify the probability of catching the disease. The study primarily focused on the presence of symptoms to the patients already hospitalized and diagnosed; thus, knowing the relationship between the attributional style and depression we tried to analyze to what extent the cancer patients appeal to negative attributions specific to depression.

The data obtained by us support the idea of Stone, Richards, A'Hern, & Hardy (2000) as well as Cohen's, namely that social support operates as a buffer of stress through the perception that others will provide the appropriate help (Cohen, Hettler, & Park, 1997; Cohen, 2004). The belief that the others will provide the necessary resources can support the perceived capability of accommodation by changing the assessment of the situation and reducing the stress. The buffer effect is stronger during the turning points when the individual needs help and is receptive to it.

We focused on the perceived social support, therefore the results indicate an extended perception of the social support for the patients diagnosed

with cancer. Although the previous studies noted a decline and withdrawal from social relations (isolation or solitude) of cancer patients, the term "perceived social support" explains the obtained results.

We sustain the influence of the social support on the functioning level in the case of the patients in the stages III and IV of disease and of the personal attributional style factor, but not the self-esteem.

We can state that an effect on the functioning level, only for the patients in stages III and IV, is represented by the way in which patients explain their ongoing condition and therefore there is a high probability that the negative explanation style to perpetuate into other circumstances of life. The fact that the negative causal attribution mechanisms were not identified in the cases of the patients in early stages of the disease leads us to consider Abramson's comments that they do not act only as distal factors but also as proximal factors with an important impact in the way in which the patient is adjusting to different contexts of life (Abramson, Seligman, & Teasdale, 1978).

The negative attributional style sustains the postulated hypothesis according to which, when confronting an uncontrollable disease, women shall manifest a disadaptive attribution pattern leading to the development of depression as Peterson & al. (1982) claimed. Besides that, hopelessness and the affiliative or negative interpersonal domain sustain the statements previously presented (Marian, Filimon, Roşeanu, & Drugaş, 2010; Marian & Filimon, 2010).

The negative global causal attributions at men render themselves evident at cancer patients but in a unexpected way they are more pronounced compared to the depression patients, probably also due to the distress generated by the treatment procedures and to the knowledge of the finality for this disease. At cancer patients the globality of the (causal) explanations is predictive for the increase of the deficits of trans-situational adaptation.

Once formed, the negative causal attributions related to accomplishment such as failure and the impossibility for finalising an activity, significantly influence the way in which cancer patients shall react to the situations perceived as being negative (actual and future), generating a symptomatology of depressive type even when the influence of the functioning level of cancer patients is constant. This information could be important for understanding the nature of the relationship between causal perception and depression even on the basis of neoplasia.

If we consider constant the level of the patients' life satisfaction, then we can reduce in an efficient way the effect of the attributions related to accomplishment and of the current thoughts about self on the functioning capacity. In situations which suppose the accomplishment, the negative attributions indicate a main effect while the current thoughts about self do not. If the cancer diagnosed patient appeals to a negative attributional style in the domain of accomplishments, then it can be blamed on the fact that he admits the gravity of the illness and its finality, which leads to an evaluation of life, failures and of the impossibility to finalize the ongoing activities, determining a decrease of the functionality.

The specific literature indicates that the negative attributional style is relevant in the case of teenagers and less in the case of the third age persons; our study sustains the applicability of the helplessness theory, attributionally reformulated, even in the case of this age group which determines us to consider the idea that the affective explanatory mechanisms of life events become active and have direct implications on survival at least in the case of cancer patients.

Along the study we prove that the negative attributional patterns are activated in advanced stages of the disease (stage III and IV) hypothetically due to the perception of the lack of control on the disease; there is the possibility that at latent level, the cognitive schema of helplessness to have once existed and to be activated together with the evolution of the disease.

The study contributes to the extension and application of the learned helplessness theory in psycho-oncology and additionally it intercepts the psycho-pathological mechanisms appeared along the disease.

We consider that helplessness vicariant may be at the basis of negative state of cancer patients, in other words, people can learn the helplessness behaviour by observing the others confronting with uncontrollable events or cancer. Consequently, is not necessary for a patient to directly experience uncontrollability for becoming helplessness, but it is enough to observe the effects to other people.

The limits of this study are connected to the number of participants and to the fact that the measuring took place only for a single time (in the description of the work procedure we motivated this aspect). It would be important to analyse to what extent the perceived social support has fluctuations along the experience of the cancer diagnosed person.

Each cancer diagnosis has its own particularities, so the conclusions of the study should be seen with a certain reserve; this does not mean that we can trace director lines considering the application of the theory sustained by us in a new domain.

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