

# Focusing: An Adjunct Treatment for Adaptive Recovery from Cancer

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## Abstract

This study evaluated the usefulness of the Experiential Focusing Method as a psychological tool in the treatment of cancer patients. The researchers measured the impact of focusing on depression, hardiness, body cathexis, body attitudes and physical activity level for twelve cancer patients (eleven women and one man) between the ages of 30 and 55, who had cancer within the last five years. The researchers matched subjects for severity of illness and randomly assigned them either to a focusing treatment group for six 90-minute weekly sessions or to a waiting list control group. Results showed a significant decrease in depression and a significant improvement in body attitudes for the treatment group when compared to the control group. A trend toward improved scores for the treatment group appeared in the hardiness scores and the body cathexis scores. At the six-month follow-up, treatment group scores did not change significantly, suggesting that subjects sustained the changes achieved with this intervention over time. The authors discuss qualitative as well as quantitative results.

## Introduction

This study investigates the Experiential Focusing Method developed by Eugene Gendlin ([1](#)) at the University of Chicago, as a psychosocial intervention for cancer patients. This approach to treatment, known as "focusing," for short, is similar to other mind/body approaches, such as guided imagery and meditation, in that it engenders a relaxation response. It is quite different from these other techniques, however, in that it enables people to access personal meanings that are carried in the body which are inaccessible to conscious awareness.

Focusing developed out of research by Gendlin ([1](#)) designed to uncover client characteristics which are relevant to whether or not psychotherapy is successful. Gendlin demonstrated that success in psychotherapy depended upon the way in which clients attended to and verbalized their inner experience. Those who made progress paid attention, in a nonbiased way, to a concretely felt, but conceptually vague, sensation in their body that they sensed was related to the problem. Words or images emerged that explicated newly felt meanings. The meanings that emerged provided missing pieces to unresolved issues in a nonanalytical fashion and enabled individuals to move out of a constricted perception of themselves or the problem. In addition, the new meanings that emerged brought physical relaxation and released

intense emotions connected to the problem. This concretely felt, but conceptually vague body sensation about the problem is called a "felt sense."

The discovery of focusing has enabled us to understand that there is a difference between the emotion or physical sensation that the individual is aware of and a more subtle bodily felt level of experience (the felt sense), which widens out from the emotion or physical sensation. If the client notices and pays attention to the felt sense, an intricate experiential field, that otherwise would not be available to consciousness, opens up. This wider experiential field carries meanings that cannot be accessed easily through a logical, analytical way of thinking. It leads to next steps of living that move one in the direction of health.

Gendlin (2) has developed a method for teaching people how to focus. Although focusing is a naturally flowing process, it is taught in steps. In order to help more people learn focusing, Gendlin (2) added a new first step to the original technique. This step is referred to as "Clearing a Space." When people are overwhelmed by emotion, negative self-talk, or the crisis nature of their situation, Clearing a Space opens up a perspective that is wider than the intense emotional experience. When Clearing a Space is used as the first step in focusing, the therapist invites the client to notice the issues that are predominant for him or her, as these issues are felt in his or her body. Once the client notes the concerns, he or she is asked to imagine placing them at a distance from him or herself, and then to notice what the inner "cleared space" is like.

According to Gendlin, Clearing a Space leads to a number of important inner experiences (2). When the concerns are placed outside the body clients report an automatic release of bodily tension. When clients observe the inner, cleared space, they often experience a larger sense of the whole of their lives, as well as a sense of well-being and a sense of how they would feel if their lives were going forward in a positive way. The experiences people report are not only cognitive ones, but also involve powerful bodily sensations. Clearing a Space is often the catalyst for clients to identify specific steps they would like to take to improve their lives. Clients often find that it is surprisingly easy to follow through on these steps. Thus, Clearing a Space may be especially helpful when illness strikes because it provides a way to transform intense emotional reactions into newly discovered positive meanings. This enables the individual to generate and perform important self-care behaviors.

The value of focusing as a treatment for individuals with cancer was first demonstrated in a single case study conducted by Grindler (3). Kanter (4) replicated the single case study as a multiple case study. Both studies looked at the impact of focusing on depression, body image and emotional expression. Both Grindler (3) and Kanter (4) found that, after treatment, subjects with cancer experienced less depression, a more intact body image, and a renewed ability to find positive meaning in significant current events in their lives. In addition, through the process of working with a "felt sense" of a problem (one of the skills of focusing), all the subjects expressed greater confidence in their ability to experience difficult emotions and work through them.

In addition to positively impacting depression, body image and emotional expression, focusing may also have a positive impact on immune functioning. A recent study utilized focusing to examine how cognitive changes and experiential involvement during an emotional disclosure protocol relate to immune functioning (5). This

particular study was able to look at the degree of experiential involvement (as measured by the Experiencing Scale (6) and its relationship to EBV- VCA antibody change scores over the study period. Eighty- two undergraduate students from the University of Miami completed the study. Students in the experimental group were asked to talk about a stressful event that they had not discussed before. They were to talk about it for a full 20 minutes as if they were talking to a close friend. The experimenter used both reflective listening and focusing responses to help the subject increase emotional involvement in the disclosure. The results showed that greater experiential involvement on the part of the students was associated with a greater decrease in Epstein-Barr Virus viral capsid antigen titres.

The present study is an attempt to investigate the usefulness of the first step of focusing, Clearing a Space, as a psychosocial intervention for individuals with cancer. Because of the bodily nature of this introspective, psychological process, and because Clearing a Space enables people to access a bodily sense of well-being that generates steps of change, we hypothesized that practicing this process would have a positive impact on recovery from cancer, and that improvement would be sustained at a six- month follow-up. Specifically, we hypothesized that accessing personal and bodily-formed meanings through the practice of Clearing a Space would lower subjects' level of depression, modify their relationship to their bodies in the direction of a more positive body cathexis and attitudes, increase their hardiness and sustain or increase their physical activity level.

## **Depression**

At least twenty-five percent of hospitalized cancer patients meet the criteria for major depression or adjustment disorder with depressed mood (7). This percentage may be an underestimate because these psychiatric disorders are underdiagnosed in the medically ill (7, 8, 9, 10, 11, 12). Patients avoid mentioning depressive symptoms unless they are asked about them, and clinicians often do not ask (13).

Untreated emotional disorders can result in prolonged suffering, increased risk of suicide, more frequent clinic visits, extended hospitalization time, and reduced compliance with treatment. Depression and anxiety can also lead to social isolation (14), which has been related to substantially higher risk for cancer mortality (15). Psychotherapeutic treatment of depression and anxiety has been shown to positively impact quality of life and the course of illness (16, 17). Successful treatment helps sustain health maintenance behaviors, positively effects immune function and endocrine environment (18) and reduces disease-related symptoms such as pain and nausea (19).

## **Body Image**

Few studies have been done on the cancer patient's relationship to his or her body. Historically, theorists have hypothesized that there is a relationship between body self-concept and overall self-esteem (20), but only recently have scales to measure "body-concept" been developed (21). Poor body image or body concept may contribute to health decline. If a person with cancer feels betrayed by his or her body, this could lead to an overall decline in self- esteem, which could result in depression and lead to poor care of one's body.

Achterberg (22) found that patients' perceptions of the body as unable to fight disease predicted poor outcomes. The patients with poorer outcomes also showed more denial and a stronger external locus of control. Many professionals (23) have observed that one psychological consequence of cancer is that patients become angry at and feel betrayed by their bodies. The body becomes an enemy instead of an ally. Kanter (4) and Gendlin, et al. (3) observed such a pattern in the people they worked with. Strong negative statements, such as "I just cut that part off" and "I hate my body," were not uncommon.

## Hardiness

Hardiness is a construct developed by Kobasa (24) as the result of a study investigating whether or not there was a relationship between personality traits and the maintenance of physical health in business executives who were under stress. The executives who remained healthy experienced stress as a challenge (the "challenge" factor), did not feel alienated from their jobs or families ("commitment"), and had an internal locus of control ("control"). The Hardiness Scale measures challenge, commitment and control, the three coping attitudes that define the hardy personality (25).

Investigators have found that individuals with high levels of hardiness have an attributional style that is different from those with low hardiness (26). Through correlating the results of the Hardiness Scale and the Attributional Style Questionnaire, investigators have found that high hardy individuals tend to perceive positive events as relatively important and negative events as relatively unimportant (27). Individuals high in hardiness experience less anxiety and worry than individuals low in hardiness.

Williams, Wiebe and Smith (28) found that high hardy people utilize more problem-focused and support seeking measures when dealing with stress, in contrast to low hardy people who tend to use avoidance and wishful thinking. Hardiness seems to be associated with successful coping strategies. Wiebe and McCallum (29) also found a correlation between high hardiness and health behaviors. Utilizing a wide age range of male and female subjects, they found that high hardy individuals tend to have more positive health behaviors, such as diet and exercise, than low hardy individuals. These findings about hardiness make it a promising outcome measure.

## Methods

### Participants

This project involved 17 subjects, between the ages of 31 and 55, who had cancer within the last five years. We limited the age range used in order to obtain a more homogeneous sample. We selected this particular age range because research indicates that stress has the most impact on illness during the middle-aged years (30). We studied individuals who had a first diagnosis of cancer in the last five years because of evidence that the first five years after onset of cancer are the crucial ones in terms of potential for long-term survival. This selection criterion eliminates individuals who had a first cancer at a younger age. The study excluded individuals who were currently in psychotherapy or practicing a stress-reduction technique.

We obtained subjects through articles in local newspapers and contact with cancer self-help groups. Individuals who participated in the study signed consent forms which assured them that the research conformed to American Psychological Association ethical standards for research (31) and gave written permission for the researchers to contact their physician to obtain information about their diagnosis and the stage of their cancer.

Each subject provided the following information: age, gender, diagnosis, date of onset of the cancer, treatment, current medications, current status of their illness. At the end of treatment and at the six-month follow-up, subjects provided up-dated information about the status of their illness.

## Experimenters

Three clinicians (one certified focusing trainer, one advanced graduate student in clinical psychology and one doctoral level clinical psychologist) with five to eight years of experience teaching focusing served as experimenters. They received at least 32 hours of training specifically for this project. This training included supervised practice sessions using the protocol for this study to teach and guide persons with cancer through the first step of the focusing process, Clearing a Space. They were also trained to use the "Clearing a Space Check List" and their inter-rater reliability using the scale was established. The assignment of a particular trainer to a subject occurred according to scheduling needs and geographical convenience.

## Instruments

Each experimenter administered six measures to her subjects at the beginning of the waiting period (for the waiting list control subjects only), prior to treatment, at the end of treatment and six months later. The measures were the Minnesota Multiphasic Personality Inventory (MMPI) Depression Scale and L Scale, the Hardiness Scale, the Secord and Jourard Body Cathexis Scale, the Grindler Body Attitudes Scale and the Eastern Cooperative Oncology Group (ECOG) Performance Status Code.

We administered the Depression Scale and the L Scale from the Minnesota Multiphasic Personality Inventory (MMPI) (32) to measure depression and have a check on the validity of subjects' responses. The MMPI Depression Scale is frequently used in research on cancer and depression.

We administered the Hardiness Scale (25, 33) to measure the complex of personality factors shown to buffer the physiological effects of stress. Normative data are available for this scale.

We had subjects complete the Secord and Jourard Body Cathexis Scale (34) to indicate their degree of satisfaction with various body parts and processes.

We used the [Grindler Body Attitudes Scale](#), which was designed for this study, to investigate health-related attitudes toward the body after an illness. This measure looks at the degree to which a person who has had cancer is maintaining a positive attitude toward their body and the extent to which they view their body as capable of healing.

We employed the Eastern Conference Oncology Group (ECOG) Performance Status Code (35) to obtain information regarding the subjects' activity level. Subjects rated themselves on a five-point rating scale as follows: 0=fully active; 1=ambulatory, capable of light work; 2=in bed less than 50% of the time, capable of self-care; 3=in bed greater than 50% of the time, capable of only limited self-care; 4=completely bed-ridden.

In addition to the measures completed by the subjects, after each session, beginning with the second session, the experimenters completed the Clearing a Space Check List to measure the number of focusing steps the subject experienced. This measure was developed for this study by the trainers themselves, through a process of listening to taped segments of focusing sessions and clarifying distinctions between the steps of focusing, and distinctions between focusing and not focusing. In order to obtain a measure of reliability for this measure the trainers rated eight ten-minute tape-recorded focusing sessions. The reliability coefficient obtained was .84. The study obtained an overall mean score on the Clearing a Space Check List for each subject.

## Design

This study was a matched-pairs experimental design, with subjects matched for severity of illness. The matching was based upon the five-year survival percentage associated with the medical diagnosis given by the subject's physician--as indicated in the text *Clinical Oncology for Medical Students and Physicians: A Multidisciplinary Approach* (36). Subjects were assigned to four categories of predicted five-year survival: 0-25%, 26-50%, 51-75%, 76-100%. Each subject in the matched pair was randomly assigned to the experimental group or the waiting list control group.

Subjects assigned to the experimental group completed the pre-treatment measures and then participated in the six-week training process. Subjects assigned to the waiting list control group completed the pre-treatment measures and waited four weeks before the treatment began. At the end of the four-week waiting period, they completed the questionnaires again before beginning the six-week training process. Both groups completed the questionnaires immediately following the sixth training session. Six months after the completion of training, both groups filled out the questionnaires for the final time and participated in a directed interview.

## Intervention

The experimenters used the standard training protocol described by Gendlin (2) to teach the process of Clearing a Space during six 90-minute weekly sessions. The purpose of the training was to experientially introduce each subject to the steps of this process and then to guide them through it each week.

Beginning with the second session and continuing through the sixth session, the trainer started each session by leading the subject through a brief relaxation process. In order to stimulate subjects' awareness of how they were relating to their cancer, the relaxation instructions included specific mention of the part of the body that had the cancer.

After relaxation the experimenter spent the remainder of each session guiding the subject through the steps of Clearing a Space following the protocol outlined by Gendlin (2) on pages 43-45, 71-82 and 86-87. First the experimenter taught the subject to locate a "felt sense" of a problem or concern in their bodies. Then the experimenter taught the subject to find a word, phrase or image (a "handle") that captured the felt sense as precisely as possible. Next the experimenter taught the subject to metaphorically place the felt sense of the problem or concern outside their body, at a comfortable distance from themselves, in order to create an inner experience of having a space between themselves and the concern. The subject repeated this process until every concern felt in their body had moved outside their body (usually two to four concerns). Once this had occurred, subjects discovered an open space in their body where they experienced an overall felt sense of well-being or "ok-ness." They were asked to find a handle to capture and strengthen this sense of well-being. They were invited to notice what steps of change emerged from this "cleared space."

After a subject completed the Clearing a Space Process, the experimenter asked the subject if there was anything further they wanted to say. If the subject explored personal material, the experimenter responded with reflective listening (as outlined by Gendlin (2) on pages 118-147).

Beginning with Session 2, the experimenters completed the Clearing a Space Check List to indicate which of the nine steps of the process were accomplished in each session. They also tape recorded each session. As a fidelity check, the principal investigator evaluated one randomly selected tape from each experimenter.

Six months after the last training session, the experimenters contacted their subjects to arrange a follow-up interview. Prior to the interview each subject completed the four questionnaires for the final time.

## Results

Of the 17 subjects who began the study, 12 successfully completed it. Five were in the treatment group and seven were in the control group. These 12 subjects included 11 females and one male. The ages of the 12 subjects ranged from 31 to 52, with a mean age of 41. The mean time since onset of their cancer was 1.24 years. Eight of the subjects were diagnosed with breast cancer. The diagnoses of the remaining four subjects were, respectively: ovarian cancer, metastatic adenocarcinoma of the pancreas, multifocal papillary follicular carcinoma of the thyroid, and diffuse mixed cell lymphoma. Subjects were in the following cancer stages: Stage I, 2 subjects; Stage II, 4; Stage III, 3; Stage IV, 3. As to likelihood of five-year survival, based on physician diagnosis, two subjects were in the 0-25% probability of five year survival category, three were in the 26-50% category, five were in the 52-75% category and two were in the 76-100% category.

Attrition of three subjects from the experimental group was due to one subject revealing after treatment began that she was already in therapy, one subject becoming too ill to continue and one subject filling out the forms in a nonstandard fashion. Two subjects were lost from the control group because one developed a job conflict and the second revealed that the onset of her cancer was longer than five years earlier. The five subjects who dropped out were similar to those who



completed treatment on the demographic measures and represented each percentage category of five- year survival rates.

The mean pre-intervention depression score for the twelve subjects was 77, placing this sample in the clinically depressed range. Depression scores were calculated using both the standard scoring system and an alternate scoring system which omitted physiological symptoms of depression, which could result from physical illness. Since the two scores correlated very highly ( $r=.98$ ,  $p<.05$ ), the standard scoring system was used.

The mean pre-intervention Hardiness score for the twelve subjects was 54.9, which is below the 74.05 mean established by the Hardiness Institute using a sample size of 1409 people.

The overall male and female per-item means established by Secord and Jourard (34) for the Body Cathexis Scale are 3.43 for males and 3.46 for females. The pre-intervention per- item mean for this sample was 3.21, with lower scores indicating a less positive attitude toward various body parts.

The range of possible scores for the Grindler Body Attitudes Scale is 30-150. The pre-intervention mean score for the 12 subjects was 92.4. Because this was the first use of the Grindler Body Attitudes Scale no norms for it were available. We evaluated its validity by correlating it with the Body Cathexis Scale. The two scales were correlated significantly ( $r=.62$ ,  $p<.05$ ). We evaluated the reliability of the scale using a Spearman-Brown Split Half Reliability Test and found a reliability coefficient of .88, which showed the internal consistency of the questionnaire.

In order to determine whether subjects assigned to different experimenters differed from one another, we computed a one- way analysis of variance, using experimenter as the independent variable. The analysis did not reveal any significant effect of experimenter.

In order to determine whether experimental and control group subjects were drawn from the same population we computed a one-way analysis of variance on the four pre-treatment outcome measures, using group status as an independent variable. The analysis did not reveal any pre-treatment differences between the two groups.

The central hypothesis in this investigation was that the six weekly focusing sessions would lower depression, increase hardiness, improve body cathexis and body attitudes and increase activity level in the experimental group, as compared to the control group. All the dependent variables changed in the predicted direction (see Table 1). The hypothesis was tested statistically using paired-samples one-tailed t tests to compare the pre- and post-treatment scores for the experimental group to the initial scores and the end of wait period scores for the control group, for each of the dependent variables.

Results showed a significant decrease in depression in the experimental group (M difference = -6.6 raw score) as compared to the control group (M difference = +1.0 raw score),  $t(4) = 2.90$ ,  $p < .025$ .



The results showed a significant increase in positive body attitudes, as measured by the Grindler Body Attitudes Scale for the experimental group (M difference = +22.2 points) compared to the control group (M difference = -1.8),  $t(4) = 3.13$ ,  $p < .02$ .

The results also indicated a trend toward a significant difference between the groups in Hardiness. Scores in the experimental group showed an increase (M difference = +10.2) while scores in the control group decreased (M difference = -3.0),  $t(4) = 1.94$ ,  $p < .06$ .

The body cathexis scores also showed a trend toward significance, with a greater increase in the experimental group's scores (M difference = +11.43) than the control group's scores (M difference = +.09),  $t(4) = 2.00$ ,  $p < .06$ .

The hypothesis that the experimental group would show larger changes in activity level, as measured by the ECOG rating scale, was not supported. Four of the subjects in the experimental group and four of the subjects in the control group showed no change in ECOG level. It was not possible to do statistical tests on scores which had so little variance.

The study's second hypothesis was that the effect of treatment would continue over time. Table 1 shows that all the scores, except Body Attitudes, were even better six months after treatment than they were immediately after treatment for the experimental group.

A one-way repeated measures Analysis of Variance was calculated to compare the experimental subjects' scores at the end of treatment to their scores six months after treatment for each dependent measure. No significant differences emerged for any of the dependent variables. This finding is consistent with hypothesis that the subjects would maintain the improvements they had made.

In order to determine whether subjects' ability to use the focusing intervention was correlated with changes in the dependent variables, Spearman Brown correlations were computed for degree of focusing and the change in each of the dependent variables from pre- to post-treatment. No significant correlation was found between degree of focusing and depression ( $r = .28$ ,  $p < .37$ ) or hardiness ( $r = .07$ ,  $p < .83$ ). However, focusing and the body cathexis measure did correlate positively ( $r = .69$ ,  $p < .01$ ), indicating that subjects who engaged in more steps of focusing during treatment also showed more of an improvement in positive attitudes toward their bodies from pre- to post-treatment. Focusing and the body attitudes measure also correlated in a positive direction, but not significantly ( $r = .51$ ,  $p < .09$ ).

In a similar way, correlations between focusing and the pre- to post-treatment change in the hardiness sub-scales (Commitment, Control, and Challenge) were examined. Focusing and Commitment were significantly related ( $r = .67$ ,  $p < .04$ ). Thus, subjects who used more steps of focusing also became more motivated to deal with stressful events through further commitment and adaptive involvement, as opposed to becoming alienated. No significant correlations were found between number of steps of focusing attained and the hardiness scales of Control ( $r = .23$ ,  $p < .52$ ) and Challenge ( $r = .07$ ,  $p < .86$ ).

In order to determine whether the dependent variables had a relationship to subjects' ability to use focusing, Spearman Brown correlations between focusing and

the pre-treatment measures were obtained. The only relationship which approached significance was a negative correlation between number of steps of focusing attained and level of depression ( $r = -.56, p < .06$ ). This indicates that subjects who were more depressed at the beginning of the study were less successful in learning to follow the steps of focusing.

Finally, an analysis of variance was used to determine whether degree of focusing was related to subjects' expected five year survival category. No relationship was found ( $F = 1.32, p < .35$ ).

## Qualitative Findings

In addition to the quantitative results, which shed light on the usefulness of focusing as a psychological intervention to aid in the recovery from cancer, subjective findings are also of interest.

The experimenters observed that many of the subjects identified a "felt sense" of the fear of dying. Such an ultimate fear was generally experienced as overwhelming and terrifying. However, when the experimenter asked the subject to place this fear at a comfortable distance outside the body and attend to the cleared space within, the subjects were often able to discover a place within the body that was not only free from the fear of death but was associated with physical health and well-being. Subjects often described this cleared space as "the old me" or "how I felt before I got sick." This experience lessened the impact of the fear of dying and often evolved into a stronger commitment to life, accompanied by less preoccupation with dying.

The experimenters observed that after attending to the cleared space for a moment the subjects often spontaneously generated specific ideas about behavioral changes which would lead to improved self-care. Subjects consistently reported that they were later able to carry out these behavioral changes easily. For example, one subject generated the idea of riding her bicycle for exercise in order to lose weight. This plan of action felt right in her body. She began bike riding on a regular basis and, six months later, had continued to do so. Another subject realized that she spent too much of her time in a care-taker role. She had the idea that, for the first time, she would refuse to host the family's Thanksgiving dinner. She was easily able to follow through on this plan.

Putting the felt sense outside the body and experiencing the cleared space seemed to be the catalyst for a reduction in anxiety about dying and for the development of new coping strategies.

## Discussion

Previous research has shown relationships between physical health and cognitive processes, emotional states and attitudes toward the body. This is particularly important because the dramatic rise in stress-related, chronic illnesses in our country has redefined the nature of recovery to include long-term adaptation to illness. The purpose of this study was to evaluate the effectiveness of focusing (2) as a psychological tool to aid in the recovery from and adjustment to cancer. It was hypothesized that six sessions of focusing would lower depression, increase

hardiness, increase positive body cathexis and body attitudes, and improve daily functioning.

This study provides evidence that focusing leads to a significant lowering of depression ( $p < .025$ ) and a significant improvement in body attitudes ( $p < .02$ ). The use of the steps of focusing is correlated .69 with an improvement in body attitudes ( $p < .01$ ). The use of the steps of focusing is also correlated with an increase in scores on the Commitment Scale, one of the Hardiness sub-scales ( $r = .67$ ,  $p < .04$ ). The six-month follow-up shows that the impact of focusing is maintained over time. The qualitative results show that subjects report decreases in fear of dying and major positive behavioral changes in self care, which they are able to maintain over time.

Additional research is needed to replicate this study. Because of its small sample size results are only suggestive. Statistically significant results in spite of a small sample size merit further investigation, however. The heterogeneity of diagnoses in this study increases its generalizability. Additional information could be obtained from a replication of this study using subjects with just one type of cancer, however.

A larger study than this one could include a longer follow-up time and an attention-placebo control group, rather than a no treatment control. It would be very interesting to look at the impact of treatment on more objective dependent measures, such as biological measures of immunocompetence.

It is also important to study other ways in which focusing could be used to help people with cancer. It could be provided as a preventive treatment for those who are at risk for cancer. It could also be made available immediately after a diagnosis of cancer to help people handle the emotional and physical difficulties that often accompany surgery, chemotherapy and radiation treatments.

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**Table 1**  
**Pre-Treatment, Post-Treatment (or end of Waiting Period) and**  
**Follow-Up Scores for Experimental (E) and Control (C) Groups**

	Pre-Treatment		Post-Treatment		Follow-Up
	E	C	E	C	E
Depression	72	76	57		49
Hardiness	48.8	61.8	59		64
Body Cathexis	152.2	151	161		178
Body Attitudes	94.4	96	117		116

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