
IN
Mind-Body Medicine

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In this issue

In one way or another, nearly every contribution to this issue picks up on concerns discussed in previous articles.

This is obvious in the responses to two prior contributions. One response, "The courage to change and the serenity to accept"—Further comments on fighting spirit and breast cancer," by John A. Astin, Shauna L. Shapiro, Carolyn E. Schwartz, and Deane H. Shapiro, carries forward separate efforts by Alastair Cunningham and Henry Dreher to explain why a recent study of some 600 women with breast cancer failed to find an association between the coping style of "fighting spirit" and the women's survival rates, a persistent finding in previous studies ("A new study [Watson et al.] on 'fighting spirit' and breast cancer," Spring 2000). Cunningham and Dreher said that one problem was unrecognized deficiencies in the scale used to identify fighting spirit, the Mental Adjustment to Cancer, or MAC, scale. Astin and his colleagues take the analysis of the MAC scale deeper. A critical issue when facing a possibly terminal illness, they say, is control. An individual can exercise control in two distinct ways. When change is possible, control is expressed through the effort to bring about change, but when change is not possible, control is expressed through serene acceptance. The MAC scale, they note, recognizes only the first type of control—fighting spirit.

In the second response, "A challenge to the mind-body movement," Henry Dreher both commends Michael Lerner's portrait of the current status of the mind-body movement ("Mind-body health at 25: An assessment," Fall 2000) and takes issue with some of Lerner's judgments. Dreher agrees with Lerner that the mind-body movement fails to acknowledge and do something about the social context that contributes to illness, but he disagrees with Lerner that mind-body medicine is being coopted and "commodified" by biomedicine and the market place.

Another article links up with previous articles in a different way—unknowingly. In "Social

relationships and health: Challenges for measure and intervention," Sheldon Cohen, Benjamin H. Gottlieb, and Lynn G. Underwood systematically review diverse efforts to identify the features of social support that contribute to better health. Their observation that the benefits of social support may partly depend on the characteristics of the people receiving it—as they write, "more concerted efforts should be made to identify the characteristics of those who benefit most and least from the support process"—unwittingly reflects back to two related *Advances'* articles published after the review was completed. In an exploratory study of cancer patients by Alastair Cunningham and colleagues ("Association of involvement in psychological self-regulation with longer survival in patients with metastatic cancer," Fall 2000), the researchers found that the patients' length of survival correlated with their involvement in a self-help program. In an editorial on the study, Theodore Pincus enumerated many other examples of studies that, in his view, allowed him to say "yes" to the radical question posed in his title: "Are actions of patients almost always as important as actions of health professionals in long-term outcomes of chronic diseases?" (Fall 2000). Could it be that the success of social support interventions depend (in part) on the "actions" of those receiving it—on what people do and not just on what is done to people—as appears to be true for the people in Cunningham's study and the people suffering from assorted chronic diseases in the studies outlined by Pincus?

Finally, in the feature article, "A model of spirituality for psychotherapy and other fields of mind-body medicine" Ruth Cohn Bolletino continues an examination she began in "The need for a new ethical model in medicine: A challenge for conventional, alternative, and complementary practitioners" (Winter 1998). In the early article, she was stimulated to develop a new model of professional ethics "adequate to the needs of a biopsychosocial model of illness and health." In the current article, she builds on her earlier

“The courage to change and the serenity to accept”—Further comments on fighting spirit and breast cancer

John A. Astin, Shauna L. Shapiro, Carolyn E. Schwartz, and Deane H. Shapiro

John A Astin PhD, Complementary Medicine Program, University of Maryland School of Medicine; Shauna L Shapiro MA, Department of Psychology, University of Arizona; Carolyn E Schwartz ScD University of Massachusetts Medical School; Deane H Shapiro PhD University of California, Irvine.

God, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference.

Reinhold Neibuhr

We read with great interest the recent comments in *Advances* by Alastair Cunningham (2000) and Henry Dreher (2000) concerning “fighting spirit” and the implications of the recent study of Watson et al. (1999) that failed to show an association between the construct of fighting spirit and survival from breast cancer. While we concur with many of the issues raised by both Cunningham and Dreher in their thoughtful commentaries, there are several additional points stemming from our own theoretical and empirical work in these areas that we felt important to highlight.

In a series of papers and books (Astin et al. 1999; Astin et al. 1999; Shapiro & Astin 1998; Shapiro et al. 1996), we have written extensively on the construct of control and its importance in mental and physical health. We have argued that control is a highly complex and multidimensional construct and have outlined a theory (Shapiro & Astin 1998) and a measure (Shapiro 1994) that build on and extend previous research in these areas. As we have discussed elsewhere (Shapiro & Astin 1998; Shapiro et al. 1996), research suggests that Western psychology’s understanding of

control as active and instrumental has many culture-bound features. Because of this bias, the potential negative consequences of active/assertive control efforts have not been adequately considered.

This limited view is reflected in most control assessment inventories—notably, in this context, the Mental Adjustment to Cancer (MAC) Scale used in studies by Watson and others to explore the association between control as expressed in fighting spirit and survival time in women with breast cancer. The MAC scale (Watson et al. 1988) and similar control measures in other studies do not distinguish between what we refer to as *positive yielding* (acceptance) and *negative yielding* (resignation or fatalism). Further, our model suggests that in response to feelings of loss of control, people employ four distinct modes or characteristic ways of regaining a sense of control or coping. As outlined in Figure 1, the four modes are *positive assertive*, *positive yielding*, *negative assertive*, and *negative yielding*.

While the positive assertive mode of control closely parallels elements of the MAC’s “fighting spirit” construct and the negative yielding mode parallels the MAC’s “hopelessness/fatalism” construct, previous psychometric analyses (Osborne et al. 1999, Schwartz et al. 1992) have noted that the MAC constructs (Watson et al. 1988), particularly fighting spirit, appear to be considerably more complex than was originally thought. For example, Osborne et al.’s factor analytic study (1999) suggests that fighting spirit contains two distinct components, minimizing the illness and holding a positive orientation; additionally, Schwartz et al.’s analysis (1992) reveals a factor that the authors labeled as “positive re-appraisal” and that contains items both from the original fighting spirit factor and

Fig.1 Modes of control: a four-quadrant model.

	Assertive	Yielding
Positive	POSITIVE ASSERTIVE Active/change	POSITIVE YIELDING Letting go/accepting
Negative	NEGATIVE ASSERTIVE Overcontrol	NEGATIVE YIELDING Helplessness/passivity

from the fatalism factor. Along these lines, then, if one looks simply at the “face validity” of several MAC items, it becomes clear that the measure may not be tapping uniform conceptual constructs. For instance, the belief that “nothing makes a difference” would seem to capture an obviously negative or fatalistic expression, as the MAC scale indicates, but another fatalistic expression, the statement that “I’ve had a good life, what’s left is a bonus,” may not represent fatalism or helplessness so much as a positive form of acceptance and surrender. Contrary to the MAC perspective, our model suggests that yielding or letting go of active control (that is, giving up “fighting spirit”) is not always maladaptive (that is, does not always represent helplessness or fatalism). This letting go may, in fact, represent a positive acceptance of coming to terms with things as they are, what we term “positive yielding” control.

Accordingly, one reason that the fighting spirit construct may not have been associated with more positive outcomes in the recent Watson et al. study (1999) is that the MAC measure (Watson et al. 1988) did not distinguish between the positive and negative dimensions of the construct. In contrast, our theoretical model (and measure—Shapiro 1994) posits that efforts at assertive control (that is, fighting spirit) are not always positive and can become maladaptive, what we term “negative assertive” overcontrol. This mode involves the potentially maladaptive desire or effort to gain

active control (for example, “fight”) in situations or circumstances that are in fact outside of one’s active control. Clinically, we share the concern that patients who attempt but are unable to maintain a heroic/positive stance in the face of a life-threatening illness such as cancer may feel guilty or blame themselves. Our model would suggest that when such control efforts lead to these types of negative emotional experiences, the person is probably engaging in negative assertive (over)control. Not to distinguish between these two dimensions of fighting spirit confuses the issues.

Greer, in a recent letter to *The Lancet* (Greer 2000), has suggested that “fighting spirit” and “helplessness” are two ends of one bipolar construct and argues that Watson et al.’s finding that helplessness was associated with poorer cancer outcomes therefore implies a positive relationship between fighting spirit and cancer prognosis (though Watson et al. concluded otherwise). In general, our theoretical model would similarly predict that helplessness (negative yielding control) would be associated with poorer health outcomes while fighting spirit (positive assertive control) would be associated with more positive outcomes. However, our model further suggests that optimal health is reflected in a balanced or flexible use of assertive (fighting spirit) and yielding control modes. Based on this theory, one would predict that an individual faced with a significant stressful life event such as cancer may benefit psychologically and physically from balancing (or being able to shift between) fighting spirit/active control efforts and the ability to let go of such efforts (which as we note is not the same as being helpless or fatalistic but is a healthy form of acceptance).

We published the results of a longitudinal study last year (Astin et al. 1999) that provide preliminary empirical support for the above theoretical model. In this study, we examined the control profiles of 58 women diagnosed with breast cancer. As the model would predict, we found that a high desire for control and high active/assertive control efforts (fighting spirit)

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were associated with positive psychological adjustment to the disease only when such control efforts were coupled with high positive yielding control as well. In fact, women in this study who evidenced high desire for control and high assertive control in the absence of positive yielding control actually showed the poorest adjustment overall. We are now carrying out a follow-up to this study to examine the extent to which these distinct modes of control may be associated with physical morbidity and mortality.

Further, preliminary results from an ongoing randomized controlled trial we are conducting (funded by the National Cancer Institute) demonstrate that for women with stage II breast cancer, greater use of the two positive modes of control was associated with greater quality of life and emotional well being. Positive assertive control was related to greater sense of coherence, vitality, and overall quality of life as well as to lower depression, anger, and anxiety. Positive yielding was related to greater sense of coherence, vitality, and overall quality of life as well as to lower anxiety (Shapiro et al. 2000). This last result is consistent with the finding of Cotton and colleagues (1999) that quality of life was related to a measure of acceptance similar to the positive yielding mode of control.

Dreher (2000) suggests that women who had no single predominant coping response may have fared better than other subgroups in the Watson et al. study. He posits that this group's more favorable prognosis may have been the result of a greater capacity to shift between coping styles (be flexible—Schwartz et al. 1998) in how one responds or copes depending on the exigencies of the moment, akin to Cantor's "resistance-surrender" cycle (Cantor 1978). We believe the findings from our studies (Astin et al. 1999; Shapiro et al. 2000) lend preliminary support to Dreher's insightful speculations and point to the potential importance of balancing active efforts for control ("the courage to change") with the ability to let go ("the serenity to accept"), realizing that there is often much in life that is outside of our personal control.

References

- Astin JA, Anton-Culver H, Schwartz CE et al. 1999 Sense of control and adjustment to breast cancer: the importance of balancing control coping styles. *Behavioral Medicine* 25:101–109
- Astin JA, Shapiro SL, Lee RA, Shapiro DH Jr 1999 The construct of control in mind–body medicine: implications for healthcare. *Alternative Therapies in Health and Medicine* 5:42–47
- Cantor RC 1978 *And A Time to Live: Toward Emotional Well-being During the Crisis of Cancer*. New York: Harper & Row
- Cotton SP, Levine EG, Fitzpatrick CM et al. 1999 Exploring the relationships among spiritual well-being, quality of life and psychological adjustment in women with breast cancer. *Psycho-oncology* 8:429–438
- Cunningham AJ 2000 Brief comment on Watson et al. *Advances in Mind–Body Medicine* 16:118–127
- Dreher H 2000 Beyond fighting spirit: What mind-states influence cancer survival. *Advances in Mind–Body Medicine* 16:118–127
- Greer S 2000 Fighting spirit in patients with cancer. *The Lancet* 355:847
- Osborne RH, Elsworth GR, Kissane DW, Burke SA, Hopper JL 1999 The Mental Adjustment to Cancer (MAC) Scale: Replication and refinement in 632 breast cancer patients. *Psychological Medicine* 29
- Schwartz CE, Daltroy LH, Brant U, Friedman R, Stolbach L 1992 A psychometric analysis of the Mental Adjustment to Cancer Scale. *Psychological Medicine* 22:203–210
- Schwartz CE, Peng CK, Lester N, Daltroy L, Goldberger A 1998 Coping behaviour in health and disease: Assessment with a card-sort game. *Behavioral Medicine* 24:41–44
- Shapiro DH 1994 *Manual for the Shapiro Control Inventory (SCI)*. San Jose, CA: Behaviordata
- Shapiro DH, Astin JA 1998 *Control Therapy: An integrated approach to psychotherapy, health, and healing*. New York: John Wiley
- Shapiro DH, Schwartz CE, Astin JA 1996 Controlling ourselves, controlling our world: Psychology's role in understanding positive and negative consequences of seeking and gaining control. *American Psychologist* 51:1213–1230
- Shapiro SL, Schwartz CE, Lopez AM, Kurker SF, Bootzin R, Lake D, Figueroa AG, Braden CJ 2000 NCI Grant #1 RO3 CA83342-01. Unpublished findings. University of Arizona Cancer Center and University of Arizona Department of Psychology
- Watson M, Greer S, Young J, Inayat Q, Burgess C, Robertson B 1988 Development of a questionnaire measure of adjustment to cancer: The MAC scale. *Psychological Medicine* 18:203–209
- Watson M, Haviland JS, Greer S, Davidson J, Bliss JM 1999 Influence of psychological response on survival in breast cancer: A population-based cohort study (see comments). *The Lancet* 354:1331–1336

Comment by Steven Greer

I should like to thank Dr Astin and his colleagues for their thoughtful and thought-provoking comments. Their proposed model is both heuristically valuable and clinically relevant. Of particular interest is their discussion of fighting spirit and acceptance. During the course of cancers, it is in the early and middle stages of the illness that the adoption of fighting spirit—that is, a positive, active coping response (Greer et al. 1992)—is appropriate as a means of improving quality of life (Greer et al. 1992) and, possibly, as a contribution to survival (Greer et al. 1979, Morris et al. 1992). In advanced and terminal illness, however, fighting to be cured becomes both unrealistic and counterproductive. There comes a time when acceptance is necessary. It is here that Astin and colleague's model is most valuable, particularly their differentiation between positive yielding (acceptance) and negative yielding (fatalism). The MAC scale measured the latter but not the former.

My clinical work in the last few years has been with terminally ill patients and their partners and relatives. Cognitive-behavior therapy with these patients and their partners involves encouraging acceptance—that is, coming to terms with their unfortunate situation—while at the same time exploring ways of promoting and maintaining psychological well-being in the face of their distress. In my experience, this somewhat daunting task is facilitated greatly by basing therapy on Folkman's revised model of the coping process (1997) with its emphasis on meaning-based coping (Folkman & Greer 2000).

References

- Folkman S 1997 Positive psychological states and coping with severe stress. *Social Science & Medicine* 45:1207-1221
- Folkman S, Greer S 2000 Promoting psychological well-being in the face of serious illness: when theory, research and practice inform each other. *Psycho-Oncology* 9:11-19

- Greer S 2000 Fighting spirit. *Advances in Mind-Body Medicine* 16:157-158
- Greer S, Morris T, Pettingale KW 1979 Psychological response to breast cancer: effect on outcome. *The Lancet* ii:785-787
- Greer S, Moorey S, Baruch JDR et al. 1992 Adjuvant psychological therapy for patients with cancer: a prospective randomized trial. *British Medical Journal* 304:675-680
- Morris T, Pettingale K, Haybittle J 1992 Psychological response to cancer diagnosis and disease outcome in patients with breast cancer and lymphoma. *Psycho-Oncology* 1:105-114

Comment by Margaret Watson

The authors raise a number of points which merit further investigation. They also raise a number of critical points about the mental adjustment to cancer scale. However, they have not cited all of the relevant literature in this respect. Two recent studies (Schnoll et al. 1998, Nordin et al. 1999) have examined the factor structure of the mental adjustment to cancer scale. Both have confirmed the factor structure with some minor variation.

Astin and colleagues have also cited Greer's comment on the fighting spirit and the helpless-hopeless sub-scales, but have failed to cite our reply to these comments (Watson et al. 2000) which clarify the issue about the relationship between these two sub-scales.

They also comment about flexibility in coping, and the question has been raised about whether patients in our study showing no predominant coping response may actually be flexible copers. This is an interesting question, but the group in our study was too small to allow a survivor analysis. This analysis would be under-powered, and it would be spurious to draw conclusions on the basis of these data.

Otherwise, the issues raised by Astin and colleagues are of interest and merit further investigation.

References

- Schnoll RA et al. 1998 Using two-factor structures of the mental adjustment to cancer (MAC) scale for

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- assessing adaptation to breast cancer. *Psycho-Oncology*: 7:424-435
- Nordin K et al. 1999 The mental adjustment to cancer scale – A psychometric analysis and the concept of coping. *Psycho-Oncology*: 8:250-259
- Watson M et al. 2000 Influence of psychological response on survival in breast cancer. A population based cohort study (Author's response to letter by Greer). *The Lancet* 355:348