Optimism about Cancer Enhances Mood by Reducing Negative Social Relations

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We tested the hypothesis that women who are more optimistic about their recovery from cancer have better emotional adjustment because they evoke more positive and fewer negative reactions from others. Data were collected from good prognosis breast and colon cancer patients (N=97) at 3 mos (T1) and 11 mos (T2) post-diagnosis. T1 optimism was associated with lower T2 negative affect and higher T2 positive affect, after statistically controlling for level of T1 affect. More importantly, the relation between optimism and affect could be explained by the quality of patients' relationships. Women who were more optimistic about their cancer had better emotional adjustment because they had fewer negative reactions from others when they talked about their cancer. These findings suggest that people who are pessimistic about their recovery from cancer may benefit from participating in social support groups or receiving counseling services.

Keywords: Optimism, pessimism, self-presentation, social support, social constraints, psychooncology, breast cancer, colon cancer, quality of life

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People vary greatly in their emotional responses to chronic or life-threatening illnesses: while some are emotionally unaffected, others experience extreme anxiety and depression (Taylor & Aspinwall, 1990). The personality trait of optimism appears to be an important predictor of emotional adjustment in people with cancer (Carver et al., 1993; Carver et al., 1994; Curbow, Somerfield, Baker, Wingard, & Legro, 1993; Friedman et al., 1992), heart disease (Fitzgerald, Tennen, Affleck, & Pransky, 1993; Scheier et al., 1989), and AIDS (Taylor et al., 1992). Optimists not only experience fewer physical and psychological symptoms (Scheier & Carver, 1985, 1992), they may exhibit faster recovery from some illnesses (Scheier, et al., 1989). There is evidence that optimists fare better than pessimists do because they use more adaptive
methods of coping (Scheier, Weintraub, & Carver, 1986). We believe that optimists may also benefit from their self-presentation to others. Specifically, optimists may evoke fewer negative social interactions and more positive social interactions because they present themselves as coping well with illnesses. The positive and supportive social responses to optimists should facilitate their emotional adjustment to illnesses.

In the present study, we examined the influence of optimism on the interpersonal relationships and emotional adjustment of women with cancer. Why should level of optimism influence the quality of cancer patients' interpersonal relationships? People who are optimistic tend to have generalized expectancies for positive outcomes in their lives. We believe that optimistic or pessimistic attitudes are expressed during interactions with others. Because pessimists have negative expectations for the future, they are likely to express distress and feelings of helplessness while coping with cancer. People who express negative affect are unpleasant to be with, so others often avoid them (Rook, Pietromonaco, & Lewis, 1994). Pessimists also might reject others' attempts to make positive reappraisals. Thus, support providers may be frustrated that their efforts to provide comfort and advice have little impact on a pessimists beliefs about cancer and its aftermath.

Optimists on the other hand may inspire potential supporters because they are hopeful about the future during dire times. By expressing optimism, cancer patients may comfort members of their support network, making it easier for the supporters to spend time with them. There is experimental evidence that people are more likely to accept opportunities to interact with optimists than with pessimists (Carver, Kus, & Scheier 1994). Silver, Wortman, and Crofton (1990) found that people who presented themselves as coping poorly with cancer (i.e., expressing pessimism, helplessness, and negative emotions) were perceived by others as less attractive and less desirable to spend time with than people presenting themselves as coping well with cancer.

We believe that the interpersonal consequences of optimistic or pessimistic self-presentation will influence psychological adjustment to cancer. People diagnosed with cancer often feel an urge to talk about their illness and to seek comfort and advice from close family and friends (Dunkel-Schetter, 1984; Dunkel-Schetter & Wortman, 1982; Rose, 1990). To the extent that people are optimistic they will probably receive the support that they need (cf. Dougall, Hyman, Hayward, McFeeley, & Baum, 1996; Scheier et al., 1986). However, to the extent that people are pessimistic they will probably have inadequate support and constraints on their ability to talk with others about their cancer-related thoughts and concerns. Previous research has shown that inadequate social support (Neulineg & Winefield, 1988) and constraints on talking (Lepore & Helgeson, 1998) can impede psychological adjustment to cancer.

HYPOTHESES

We hypothesized that (a) cancer patients who are optimistic about their illness would have better emotional adjustment than their more pessimistic counterparts, and (b) the association between optimism and emotional adjustment would be mediated by the quality of patients' interpersonal relationships (see Figure 1). To test the hypothesized mediating role of social support and social constraints, we will examine whether the associations between optimism and women's emotional adjustment disappears after partialling out the effects of social support and social constraints (cf. Baron & Kenny, 1986).

METHOD

Participants

The sample consisted of 97 women who were being treated for primary breast (N = 82) or colon (N = 15) cancer. Most women had early stage cancer (46% stage 1, 40% stage 2), but a minority had a stage 3 cancer (14%). The primary treatment for all women was surgery, followed by chemotherapy (27%), radia-
FIGURE 1 Hypothesized relations between optimism about cancer, quality of social relationships and emotional adjustment

optimization (27%) or a combination of chemotherapy and radiation (46%).

The mean age of participants was 54 years (range 25 to 81). Most women were married (79%) and Caucasian (92%). The median household income level was $21,000-$30,000 a year. The highest level of education for most participants was high school (49%), but a sizable minority had less than a high school education (13%) or had college training (38%).

Procedure

Patients were recruited from the outpatient clinics of oncologists and radiation therapists practicing in southwestern Pennsylvania. The office manager in each clinic used a list of eligibility criteria to identify and refer appropriate patients. Eligibility criteria were: a) patient was a woman receiving treatment for breast or colon cancer; b) patients cancer was diagnosed within the past four months; c) patient had no previous cancer diagnosis; and d) patient had a good prognosis (i.e., physician-rated life expectancy of five years or more). Information on eligible patients was given to a research assistant, who recruited patients by telephone. Of the 116 patients approached for participation, 15 (13%) did not complete the first interview. Eight patients refused to participate, citing illness or lack of time. Four patients could never be reached by telephone after the initial contact. Three patients could not follow the structured interview and were dropped. Data from four patients who did complete the first interview were dropped from the study because they died before the second interview. Thus, 97 patients participated in the study.

The only information available on the 15 patients who did not complete the first interview was their cancer diagnosis, cancer stage, and referring oncologist. Chi-square analyses revealed no association between these variables and patients' likelihood of completing the first interview. Mortality was unrelated to cancer.

We collected data from patients using structured telephone interviews. The first interview (T1) was administered during the post-surgical period, while the patient was receiving chemotherapy or radiation treatments. On average, patients completed the first interview 3 months after their initial diagnosis. The second interview (T2) was administered eight months after the first. On average, patients completed the second interview 11 months after their initial diagnosis.
Measures

**Emotional adjustment**

We used the 20-item Positive and Negative Affect Schedule (PANAS; Watson, Clark, & Tellegen, 1988) to measure patients' emotional adjustment. Patients rated how much they felt each of 10 positive moods (e.g., enthusiastic, alert, inspired) and 10 negative moods (e.g., afraid, hostile, nervous) in the past week. Ratings were made on a 6-point scale (0 = not at all to 5 = extremely). Items were summed to form a positive affect (PA) and a negative affect (NA) scale. Watson et al. (1988) have presented evidence on the reliability and validity of the PA and NA factors. In the present study, the scales had good internal consistency (PA alpha = .84; NA alpha = .88).

**Optimism about cancer**

We used a modified version of the Life Orientation Test (LOT; Scheier & Carver, 1985) to measure optimism about cancer. The LOT measures generalized expectancies for positive (or negative) outcomes. We phrased the items on the LOT to tap optimism specifically related to recovery from cancer (e.g., "you are optimistic about the future course of your illness," "you have a positive attitude about your cancer"). Patients rated their agreement with the items using a 4-point scale (1 = strongly disagree to 4 = strongly agree). The scale had acceptable internal consistency (alpha = .70).

**Social constraints from spouse and family/friends**

Social constraints include any social condition that causes trauma survivors to feel unsupported, misunderstood, or otherwise alienated from their social network when they are seeking social support or attempting to discuss their trauma (Kliwer, Lepore, Oskin, & Johnson, 1998; Lepore, 1997a; Lepore & Helgeson, 1998; Lepore et al., 1996). We used a 15-item measure of social constraints on disclosure about cancer developed by Lepore (1997b). Sample items include: “[others] avoided you,” “[others] minimized your problems,” “[others] told you not to worry so much about your health,” “[others] acted uncomfortable when you talked about your illness,” “kept your feelings about your cancer to yourself, because they made [others] upset,” “got the idea that [others] didn’t want to hear about your cancer,” “[others] changed the subject when you tried to discuss your illness.” Items were rated on a 4-point frequency scale (1 = never to 4 = often). Respondents rated social constraints from two domains: spouse and family/friends. Respondents were instructed to exclude spouse from ratings of family/friends. The scales had good reliability (alphas ranged from .88 to .92) and high stability from wave 1 to wave 2 (Constraints-Spouse $r = .69$, $p < .001$; Constraints-Family/Friends $r = .71$, $p < .001$). The intercorrelations between Constraints-Spouse and Constraints-Family/Friends were positive and modest across the two waves (see Table 1).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Optimism</th>
<th>Spouse Support</th>
<th>Fam/Frn Support</th>
<th>Spouse Constraint</th>
<th>Fam/Frn Constraint</th>
<th>Positive Affect</th>
<th>Negative Affect</th>
</tr>
</thead>
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<td>Optimism</td>
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<td>-.10</td>
<td>-.10</td>
<td>-.29$^b$</td>
<td>-.27$^b$</td>
<td>.23$^a$</td>
<td>-.39$^c$</td>
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<tr>
<td>Spouse Support</td>
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<td>XX</td>
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<td>-.22</td>
<td>.27$^a$</td>
<td>.07</td>
<td>.16</td>
</tr>
<tr>
<td>Fam/Frn Support</td>
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<td>.23$^a$</td>
<td>XX</td>
<td>.10</td>
<td>.05</td>
<td>.07</td>
<td>.10</td>
</tr>
<tr>
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<td>-.22</td>
<td>-.01</td>
<td>XX</td>
<td>.38$^c$</td>
<td>.01</td>
<td>.20</td>
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<td>Fam/Frn Constraint</td>
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<td>.19</td>
<td>.12</td>
<td>.41$^c$</td>
<td>XX</td>
<td>-.03</td>
<td>.32$^c$</td>
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<tr>
<td>Positive Affect</td>
<td>.48$^c$</td>
<td>.20</td>
<td>.04</td>
<td>-.29$^a$</td>
<td>-.06</td>
<td>XX</td>
<td>-.22$^a$</td>
</tr>
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<td>Negative Affect</td>
<td>-.46$^c$</td>
<td>-.02</td>
<td>.16</td>
<td>.50$^c$</td>
<td>.45$^c$</td>
<td>-.20</td>
<td>XX</td>
</tr>
</tbody>
</table>

Note: Fam/Frn = Family and friend. Sample size = 96, except for spouse variables sample size = 75.

$a = p < .05; b = p < .01; c = p < .001.$
Social support from spouse and family/friends

We used the UCLA social support scale (Dunkel-Schetter, Feinstein, & Call, 1986) to measure how often patients received social support in coping with their cancer. Patients rated how frequently (1 = never to 4 = often) in the past month they received informational, instrumental, and emotional support from two social domains: spouse and family/friends. For example, patients rated how often family or friends “comforted you if you were upset,” “gave advice about your illness,” “helped you out with errands or household chores.” Patients’ scores on the three types of social support were averaged to form a global measure of social support for each social domain. The internal consistency of the scales was acceptable (spouse support alpha = .66; family/friend support alpha = .70). Patients’ scores on the social support scales had little association with their scores on the social constraints scales (see Table 1), indicating that the support and constraints measures tapped independent constructs.

RESULTS

Descriptive data

The concurrent, zero-order correlations between the major study variables at Time 1 (T1) and Time 2 (T2) are shown in Table 1. Many of the predicted associations in Figure 1 were obtained. Optimism was associated with higher positive affect and lower negative affect at T1 and T2. Optimism also was associated with fewer social constraints from spouse and from family/friends at T1 and T2. Social constraints from family and friends was positively correlated with negative affect at T1 and T2, but not correlated with positive affect. At T2, social constraints from spouse were positively correlated with negative affect and were inversely related to positive affect. The predicted relations between social support and optimism were not obtained, nor was social support related to affect. Thus, social support might not have a mediating role in the relation between optimism and affect. However, we still tested the potential mediating role of social support in the longitudinal analyses reported below.

Overview of the mediation analyses

Regression analyses were used to test whether social support and social constraints mediated the association between optimism and affect in a longitudinal model (i.e., T1 optimism predicting T2 affect). We followed the statistical approach suggested by Baron and Kenny (1986). The first step of the analyses was to test the longitudinal association between T1 optimism and T2 affect, after controlling for T1 affect. We predicted that optimism would be associated with lower negative affect and higher positive affect. The second step was to test the longitudinal association between T1 optimism and the T2 mediators, social support and social constraints. We predicted that optimism would be associated with higher social support and lower social constraints. The third step was to test whether T2 social support and T2 constraints were associated with T2 affect, after controlling for T1 affect. We predicted that support would be associated with lower negative affect and higher positive affect, whereas constraints would be associated with higher negative affect and lower positive affect. Finally, to test mediation, we examined whether the association between optimism and affective outcomes was diminished or eliminated after partialling out the effects of social constraints and social support.

Separate mediation analyses were conducted for the two outcomes, positive and negative affect. We further divided analyses by source of social support and social constraints (i.e., spouse versus family and friends), because the subset of married patients was smaller than the total sample. In all regression analyses, T1 affect was used as a covariate (e.g., T1 negative affect was covaried in analyses of T2 negative affect). Thus, the outcome variable was residualized affect, which can be interpreted as changes in affect (Cohen & Cohen, 1983). In addition, our analyses were always longitudinal: we used T1 optimism to predict T2 affect, support and constraints.
Optimism, spousal relationship and negative affect

These analyses are limited to those patients who were married (n = 75). T1 optimism was significantly and inversely related to residualized negative affect (Equation 1, Line 2 in Table II). After controlling for T1 negative affect, T1 optimism accounted for 9% (p<.01) of the variance in T2 negative affect. After controlling for T1 negative affect, T1 optimism also was associated with less T2 social constraints from spouse (b = -.46, t = -3.20, p < .01), but was not associated with T2 social support from spouse. Thus, the remainder of these analyses focused on the mediating role of social constraints from spouse. As predicted, more T2 spousal constraint was significantly and positively associated with residualized negative affect (Equation 2, Line 2 in Table II). Most importantly, the association between T1 optimism and residualized negative affect was no longer significant after controlling for T2 spousal constraints (Equation 3, Line 3 in Table II). After controlling for T2 spousal constraints and T1 negative affect, T1 optimism only accounted for 3% (p<.06) of the variance in T2 negative affect. Thus, spousal constraints, but not support, appeared to play a mediating role in the relation between optimism and negative affect.

<table>
<thead>
<tr>
<th>Variable</th>
<th>ΔR² (at each step)</th>
<th>Std. B (last entered)</th>
<th>Raw b (SE b) (last entered)</th>
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<td><strong>Equation 1</strong></td>
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<td>Negative Affect-T1</td>
<td>.21</td>
<td>.33</td>
<td>.35 (.11)**</td>
</tr>
<tr>
<td>Optimism-T1</td>
<td>.09</td>
<td>-.32</td>
<td>-.58 (.19)**</td>
</tr>
<tr>
<td><strong>Equation 2</strong></td>
<td></td>
<td></td>
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<tr>
<td>Negative Affect-T1</td>
<td>.21</td>
<td>.41</td>
<td>.43 (.09)**</td>
</tr>
<tr>
<td>Spouse Constraints-T2</td>
<td>.20</td>
<td>.45</td>
<td>.68 (.14)**</td>
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<td><strong>Equation 3</strong></td>
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<tr>
<td>Negative Affect-T1</td>
<td>.21</td>
<td>.34</td>
<td>.35 (.10)**</td>
</tr>
<tr>
<td>Spouse Constraints-T2</td>
<td>.20</td>
<td>.39</td>
<td>.58 (.14)**</td>
</tr>
<tr>
<td>Optimism-T1</td>
<td>.03</td>
<td>-.19</td>
<td>-.35 (.19)</td>
</tr>
</tbody>
</table>

Note: T1 = Time 1, T2 = Time 2. 
*p < .05, **p < .01, ***p < .001.

Optimism, family and friend relationships, and negative affect

These analyses included the entire sample. T1 optimism was significantly and inversely associated with residualized negative affect (Equation 1, Line 2 in Table III). After controlling for T1 negative affect, optimism accounted for 4% (p<.01) of the variance in T2 negative affect. After controlling for T1 negative affect, T1 optimism also was associated with fewer T2 social constraints from family and friends (b = -.29, t=-2.48, p<.01), but was not associated with T2 social support from family and friends. Thus, the remainder of these analyses focused on the mediating role of social constraints from family and friends. A higher level of T2 constraints from family and friends was significantly and positively associated with residualized negative affect (Equation 2, Line 2 in Table III). The association between T1 optimism and residualized negative affect was no longer significant after controlling for T2 family and friend constraints (Equation 3, Line 3 in Table III). After controlling for T1 negative affect and T2 family and friend constraints, T1 optimism only accounted for 1.5% (p>.10) of the variance in T2 negative affect. Thus, social constraints from family and friends, but not social support, appeared to play a mediating role in the relation between optimism and negative affect.
TABLE III Regression of T2 Negative Affect on T1 Optimism and T2 Constraints from Family and Friends, Controlling for T1 Negative Affect

<table>
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<th>ΔR² (at each step)</th>
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<th>Raw b (SE b) (last entered)</th>
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<td>.31</td>
<td>.47</td>
<td>.48 (.09)**</td>
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<td>-.23</td>
<td>-.41 (.17)**</td>
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<td>Negative Affect-T1</td>
<td>.31</td>
<td>.49</td>
<td>.51 (.08)**</td>
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<tr>
<td>Fam/Fr Conraint-T2</td>
<td>.13</td>
<td>.37</td>
<td>.61 (.13)**</td>
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<td><strong>Equation 3</strong></td>
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<td>.44</td>
<td>.45 (.09)**</td>
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<td>Fam/Fr Conraint-T2</td>
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<td>.33</td>
<td>.55 (.13)**</td>
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<tr>
<td>Optimism-T1</td>
<td>.02</td>
<td>-.14</td>
<td>-.25 (.16)</td>
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</table>

*Note: Fam/Fr = Family and friends. T1 = Time 1, T2 = Time 2.  
*p < .05, **p < .01, ***p < .001.*

Optimism, spousal relationship and positive affect

These analyses only included married patients. T1 optimism was significantly and positively associated with residualized positive affect (Equation 1, Line 2 in Table IV). After controlling for T1 positive affect, T1 optimism accounted for 7% (p < .01) of the variance in T2 positive affect. After controlling for T1 positive affect, T1 optimism also was associated with less T2 social constraint from spouse (b = -.47, t = -3.83, p < .001), but was not associated with T2 social support from spouse. T2 spousal constraint was significantly and inversely associated with positive affect at T2 (Equation 2, Line 2 in Table IV). Finally, the association between T1 optimism and residualized positive affect was no longer significant after controlling for T2 spousal constraints (Equation 3, Line 3 in Table IV). After controlling for T1 positive affect and T2 spouse constraints, T1 optimism only accounted for 3% (p < .07) of the variance in T2 negative affect. Thus, spousal constraints, but not support, appeared to play a mediating role in the relation between optimism and positive affect.

TABLE IV Regression of T2 Positive Affect on T1 Optimism and T2 Constraints from Spouse, Controlling for T1 Positive Affect

<table>
<thead>
<tr>
<th>Variable</th>
<th>ΔR² (at each step)</th>
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<tr>
<td>Positive Affect-T1</td>
<td>.32</td>
<td>.48</td>
<td>.54 (.10)**</td>
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<tr>
<td>Optimism-T1</td>
<td>.07</td>
<td>.27</td>
<td>.53 (.19)**</td>
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<tr>
<td><strong>Equation 2</strong></td>
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<tr>
<td>Positive Affect-T1</td>
<td>.30</td>
<td>.53</td>
<td>.60 (.10)**</td>
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<td>Spouse Constraints-T2</td>
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<td>-.46 (.15)**</td>
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<tr>
<td><strong>Equation 3</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Positive Affect-T1</td>
<td>.30</td>
<td>.48</td>
<td>.54 (.11)**</td>
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<tr>
<td>Spouse Constraints-T2</td>
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<td>-.23</td>
<td>-.35 (.16)*</td>
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<tr>
<td>Optimism-T1</td>
<td>.03</td>
<td>.18</td>
<td>.35 (.20)</td>
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</table>

*Note: T1 = Time 1, T2 = Time 2.  
*p < .05, **p < .01, ***p < .001.*
Optimism, family and friend relationships, and positive affect

These analyses included the entire sample. T1 optimism was significantly and positively associated with residualized positive affect (see Equation 1 in Table IV). After controlling for T1 positive affect, T1 optimism accounted for 8% (p < .001) of the variance in T2 positive affect. However, neither social constraints nor social support from family and friends were associated with residualized positive affect. Thus, social constraints and support from family and friends could not act as mediators of the relation between optimism and positive affect.

DISCUSSION

Consistent with our central hypotheses, female cancer patients who were more optimistic about their illness had fewer social constraints, greater positive affect and less negative affect. Further, social constraints from spouse, family and friends mediated the relation between optimism and negative affect. Only social constraints from spouse mediated the relation between optimism and positive affect. Contrary to our hypotheses, optimism was not related to level of received social support. Thus, women who were more optimistic about their cancer perceived that they had fewer social constraints but not more social support. These results have theoretical implications and practical implications for people who are recovering from cancer.

The main theoretical implication is that interpersonal variables (i.e., social constraints) can account for some of the psychological benefits of being optimistic. Previous research on optimism and adjustment has focused on the mediating role of thought processes or coping behaviors. For instance, in a sample of women treated for breast cancer, general optimism about life was shown to be related to greater acceptance, less passivity, and less denial of the cancer (Carver et al., 1993). Our results suggest that the influence of optimism does not stop at individuals' own thoughts and behaviors, but extends to the quality of their interpersonal relationships. This is consistent with the notion that the ways in which victims react to their situation can influence how others treat them (Coates, Wortman, & Abbey, 1979; Silver et al., 1990). Thus, we urge future investigators to include interpersonal process variables in theoretical models and empirical investigations of optimism and health.

The relation between optimism and negative social interactions is especially important to consider. We predicted that optimistic cancer patients would receive more social support and fewer negative social responses. While optimism was related to fewer negative social responses, it was not related to received social support. This is somewhat consistent with previous research in which no association was found between generalized optimism and support seeking in breast cancer patients (Carver et al., 1993). However, in two studies with other trauma populations, investigators have found some evidence of a positive association between optimism and social support seeking (Dougall et al., 1996; Scheier et al., 1986). Thus, while an optimistic attitude may reduce exposure to emotionally disturbing negative social responses, there is mixed evidence about its relation to seeking or receiving social support.

The lack of association between social support and adjustment was surprising to us because previous research with cancer patients has shown such a relation (Bloom & Spiegel, 1984; Jamison, Wellisch, & Pasnau, 1978; Northouse, 1988; Zemore & Shepel, 1989). Our null findings might be attributed to our measure, which focused on received support rather than perceived support availability. In studies that have compared these two dimensions of social support, perceived support tends to be more predictive of adjustment than received support (Wethington & Kessler, 1986). We choose a measure of received rather than perceived support because we hypothesized that the self-presentation of optimists (or pessimists) would actually affect the quantity of their received positive and negative interactions and not simply influence their perceptions of their social relationships.

We were not surprised that social constraints had a stronger impact on adjustment than did social support.
There is evidence from multiple studies that negative interactions have a greater impact than positive interactions on psychological adjustment (see Lepore, 1997a; Rook, 1992). While there is little empirical evidence to explain the differential effects of negative versus positive interactions, it has been postulated that negative interactions are highly salient and threatening because they occur less frequently than positive interactions (Rook & Pietromanaco, 1987). This may be especially true in the context of a health crisis, such as cancer, because most patients anticipate and receive relatively high levels of support, empathy, and assistance from their loved ones. Negative interactions generally are not anticipated by patients, and network members may even avoid topics that are sources of conflict with a cancer patient (cf. Welch-McCaffrey, Hoffman, Leigh, Loescher, & Meyinkens, 1989). In contrast to arguing, yelling, nagging and other overtly negative behaviors (e.g., Lepore, 1992; Ruehlman & Karoly, 1991), social constraints may be experienced as negative because of conflicting goals involved in the interactions between patients and their social network members. Whereas patients desire to speak openly about cancer, members of their social network may avoid such discussions.

There are several practical implications of this research. In considering these implications it is important that we do not simply blame cancer patients for their distress. While our data suggest that a cancer patient’s disposition may evoke negative responses from others, this does not imply that the patient is responsible for others’ negative responses. Our data simply imply that cancer patients who are pessimistic about their health have additional social stress to manage and therefore are at greater risk for emotional adjustment problems. One obvious solution to this problem is to encourage cancer patients to feign optimism to garner social support. This solution is problematic because patients who hide their true feelings around others may feel socially alienated. Therefore, we recommend three other courses of action for health care providers who encounter pessimistic patients.

First, accurate information about cancer, its treatment and aftermath should be provided to all patients and to their family members and other loved ones. Such information may be interpreted with a positive spin by those who tend to be optimistic, and it may also counter misinformation or fatalistic thinking about cancer among those who tend to see things in a negative light. Second, social network members should be cautioned about the effects of cancer on patients’ mood, and should be informed that sometimes patients need to be speak openly about cancer. It might be possible at this point to identify and then counsel network members who are extremely upset or otherwise uncomfortable speaking about cancer. Finally, patients who express unrealistic pessimism about their condition should be carefully monitored as they may be at risk for developing more serious mental health problems, such as clinical depression. In all cases, health care providers should strive to counter negative expectancies cancer patients may have, whether those expectancies are based on misinformation or on trait optimism or pessimism. We believe that these recommendations are limited in their appropriateness to people diagnosed with early stage cancers, such as the participants in the current study, who have a good prognosis for recovery and long-term health.

References


