

Patients and their Families Coping with Cancer Disease: Strengths and Limitations of Durkheim's Functional Perspective

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Abstract

This study aims to explain the coping processes of cancer patients and their families, by using theoretical explanations of the functional theory as outlined by Durkheim. Needed data were obtained through using two tools. These tools included a review of field literature on the subject and discussions with four focus groups. Focus groups included one composed of social workers working in hospitals, two separate groups of male and female patients who are getting treatment for cancer, and a fourth group consisted of some members of families of cancer patients, mainly mothers of children with cancer.

Findings showed that some of Durkheim's functional propositions are capable in explaining the coping process. These propositions include: any social system consists of many interrelated parts, changes in any social system create imbalance in other social systems, and the role that common values play in the reorganization process of the system. On the contrary, findings showed that the theory of functionalism, as outlined by Durkheim, faces some difficulties in relation to each of the ignorance of psychological factors, underestimating structural changes, lessening the positive effects of macro economic factors, and legitimizing gender differences. Finally, some recommendations were provided to improve the coping process of patients and their families with the cancer disease.

Key Words: Cancer, Coping, Patients, Families, Functionalism, Durkheim.

تعامل المرضى وأسرهم مع مرض السرطان: جوانب القوة والضعف في منظور دوركايم الوظيفي

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ملخص

بيّنت الدراسة كيفية تعامل المرضى وأسرهم مع مرض السرطان من خلال استخدام التفسيرات النظرية الوظيفية كما تناولها دوركايم. وتمّ جمع البيانات اللازمة باستخدام أداتين. واشتملت الأداتان على مراجعة الأدبيات المتعلقة بالموضوع ونقاش مع أربع مجموعات بؤرية. أما المجموعات البؤرية فتكونت من مجموعة من الاختصاصيين الاجتماعيين العاملين في المستشفيات، ومجموعتين منفصلتين احدهما من المرضى الذكور والاخرى من المرضى الإناث، وتكونت المجموعة الرابعة من بعض أفراد أسر مرضى السرطان بما في ذلك بعض أمهات الأطفال المصابين بالمرض.

أشارت النتائج إلى أنّ بعض مسلمات دوركايم كانت قادرة على تفسير عملية التعامل مع مرضى السرطان. واشتملت هذه المبادئ على أنّ أي نظام اجتماعي يتكون من مجموعة من الأجزاء المترابطة، وأنّ حدوث تغيير في أي نظام اجتماعي يؤدي إلى حدوث عدم اتزان في باقي الأنظمة الاجتماعية، ودور القيم المشتركة في عملية إعادة تشكيل النظام. وعلى عكس ذلك أشارت النتائج إلى أنّ النظرية الوظيفية كما صاغها دوركايم تواجه بعض الصعوبات. وهذه الصعوبات تتعلق بإغفال العوامل النفسية، وتقليل أهمية كل من التغيرات البنائية والعوامل الاقتصادية، وإضفاء الشرعية على الفروقات النوعية بين الذكور والإناث. وأخيراً قدمت الدراسة عدد من التوصيات التي يمكن أن تحسّن من عملية تفاعل المرضى وأسرهم مع مرض السرطان.

الكلمات الدالة: السرطان، التعامل، المرضى، الأسر، الوظيفية، دوركايم.

Introduction

Cancer is a health problem and a life-threatening illness. Being diagnosed with cancer is the most critical stage for patients and their families for many reasons. Some of these reasons may include having shock symptoms, such as numbness, sadness, and anxiety; a moment to make a decision about how, where, and when to get a treatment; a fear of dying, and the ambiguity of the future. Being diagnosed with cancer implies losing the status of being healthy, at least on a temporary basis. On the other hand, health, as explained by Noak(1987) is a holistic concept. It encompasses many aspects including the absence of symptoms, illness, or disability; equilibrium within oneself and the environment; a positively valued psychological experience; a process of effective coping; a potential or capacity to pursue personal goals and to cope with social and environmental demands. It is difficult to understand coping styles and behaviors of patients diagnosed with cancer in isolation from their surroundings, mainly their families. For example, Rolland(1990) pointed out that the diagnostic period, mainly for patients diagnosed with a life-threatening illness and their families, is a highly emotional and vulnerable period for the patients and their families.

There are different theoretical ways and arguments in explaining social interaction within different situations and cultures. The most dominant and visible contemporary sociological theories, even though they have their classical roots, include structural functionalism, conflict, symbolic interactionism, social exchange, and phenomenology. Each theory views social interaction in a different way. However, this paper examines strengths and limitations of Emile Durkheim's propositions(1858-1917), as a classical functional theorist, in explaining the coping processes of patients and their families to the disease of cancer, with special concern to the Jordanian culture, as well as the degree of family solidarity.

Problem of the Study

Social theory is powerless unless related to practice. Hence, this study links major assumptions of the functional approach of Durkheim to the reality of responses of patients and their family members to the disease of cancer as supported by field literature and outputs from focus group discussions with patients, their family members, and social workers working at hospitals.

Importance of the Study

Understanding factors that affect the coping processes of patients of cancer and their families is important for health care providers and para-medical professions, including medicine, nursing, psychiatry, and social work. Indeed, understanding such factors help in improving the quality of life of patients, as well as their surrounding and supportive environments, including their families. In addition, the nature and functions of the coping processes may not accurately apply to the Jordanian society, since most previous academic literature and research on the subject was conducted in Western countries, particularly the United States and Britain. Finally, this study is a pioneer in understanding the coping processes within the cultural milieu of the Jordanian society.

Purpose of the Study

The study aims to answer the following question: To what extent can major propositions of Durkheim's functional approach explain the coping processes of patients of cancer and their families to the disease?

Instruments

The study employed the following tools to gather needed data for the study:

1. Reviewing available theoretical and field literature on the subject.
2. Having four focus group discussions. These included two focus groups of Jordanian cancer patients; males and females. The reason for having two separate groups on the basis of gender is due to cultural and religious reasons. The second focus groups included some parents of children diagnosed with cancer. The fourth focus group was composed of a number of social workers working at hospitals and who have had direct contact with cancer patients and some of their family members.

Difficulties of the Study

The major difficulty which faced this study is the limited number of available filed literature on the subject of coping of patients and their family members with cancer disease in Jordan. Indeed, most of available literature is either theoretical or theoretically inadequate.

Main Propositions of Functionalism

Basic propositions or “assumptions” of the theory of functionalism, as presented by Durkheim, are that society as a social system is composed of many interrelated parts. In addition, changes in any part of that system may create an imbalance and disequilibrium in other parts. Finally, parts representing the system can reorganize in order to bring the system back to a normal state (Isajiw, 1998; Wallace and Wolf, 1986).

Findings of the Study

First: Strengths of Durkheim’s Functionalism:

Durkheim’s functional theory included some propositions that were strong enough to explain the coping processes of patients and their family members to the disease of cancer. These propositions or “assumptions” state that a social system consists of many interrelated parts. Any change in that system creates disequilibrium and imbalance in other social systems. It also includes the positive role of common values in the reorganization of the system.

Proposition 1: Any Social System Consists of Many Interrelated Parts

The first proposition of the functional theory which was adopted by Durkheim is that any social system consists of many connected and interrelated parts. This proposition emphasizes the macro-sociological focus of the functional paradigm. Durkheim believed that society, as a social system, consists of many interrelated parts. Parts of the social system have a mutual relationship and it is hard to understand or analyze any part in isolation from other parts (Wallace and Wolf, 1986). This proposition is also emphasized by the definition of health as provided by the World Health Organization, which defined health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or injury." (Cockerham, 1995, 2). Hence, health consists not only of a physical component, but also of a mental or psychological and a social component. The health system operates in a case of equilibrium and balance through many social role expectations. These social role expectations, which individuals learn from the culture of the society, are determined by a system of division of labor. Parsons (1951), for example, provided the sick role as an example. When the individual gets sick, he/she has some expectations, such as seeking medical help, and obligations, including compliance with the requirements of the healing process as determined by the medical practitioner.

The family, as indicated by Sourkes (1982, 48), may insist that the diagnosis of a life-threatening illness, such as cancer, should be hidden from its patient. Indeed, some of the social workers reported to the researcher that this is true for many cases they know at the hospitals where they work. Their justification is that hiding the diagnosis from patients reduces their suffering. A study by Tavoli et al. (2007) on cancer patients in Iran concluded that patients who did not know about their diagnosis were less distressed than patients who knew about their diagnosis. Abu-Alsundus (2003) conducted a study on 50 Jordanian children within the age category of 5-14 years of age suffering from cancer and the responses of their parents. The study found that mothers of children have the responsibility of meeting the needs of their sick children, as well as other household obligations. The researcher concluded that most mothers suffered from role conflict to meet societal and familial demands and expectations.

Outputs from focus groups’ discussions with patients and social workers supported the interrelatedness of the different parts of the social system. A nine year old female patient with cancer had surgery and was hospitalized while getting chemotherapy stated:

I know I have cancer. I do not know much about the disease because when I ask others about it they do not tell me. I know this disease is fatal if the patient does not get treated for it. I want to get treated for it, even though the needles I get hurt me, so I can get back my lost hair, play again with my friends, and go back to my school.

A 64 year old male patient with cancer at Al-Bashir Hospital summarized how cancer affected different dimensions of his life, as well as his family life:

I was living a stable life with my wife and the rest of my family. I was working in the construction area. I felt pain in my back so I visited a physician who informed me that I have an infection in my lungs. The prescribed medications did not work and my case got worse, so I went to the hospital. At the hospital, physicians found I have cancer in the spinal cord. Now I am in the terminal stage of the disease where it has spread to the marrow of the bone. My wife passed away five months before my diagnosis and my children visit me regularly.

A social worker stated how several social disturbances occur in the family life of cancer patients illustrated:

For many patients, in addition to the shock they go through after diagnosis, having a family member diagnosed with cancer creates many pressures. Children patients are usually accompanied by their mothers. Their mothers, who are sometimes working, start to think about the future of their work, whether they will be allowed or not to stay with their children during the course of treatment. Mothers also think about the ambiguous future of their children. Some of their concerns, from my own experience working with them include: whether the child will survive or not, missing school, and who will take care of the other children at home.

Proposition 2: Change in Any System or the Sub-System as a Whole Creates Imbalance in Other Systems

The second proposition of the functionalism, as presented by Durkheim, illustrates that change in any social system creates imbalance and disequilibrium in other existing social systems. Mechanic(1978, P. 25) defined disease as "some deviation from normal functioning that has undesirable consequences because it produces personal discomfort or adversely affects the individual's future health status." Cancer, as a life-threatening illness, usually leads into many undesirable consequences. For example, the diagnosis of cancer among children is a main life stressor not only for children, but also for their families(Al-Hussein Cancer Center, 2006; Goldbeck, 2001). Rolland(1990) pointed out that the anticipation of death can be as painful for the family as the death itself. In addition, the family may feel loss of a normal life as it was before the diagnosis. Also, the family believes that the patient's knowledge about the disease may increase her/his suffering. A study conducted by Sally-Ann(2005) found that many parents face difficulties regarding what to tell their children when diagnosed with cancer. It was also reported by Sheehy(2004) that having cancer among young men comes at a time when they struggle with basic tasks of early adulthood such as having relationships, establishing careers, starting families, and buying homes.

According to Celmen-Stone et al.(2002), even though the majority of elderly people lead productive and full lives, risks of frailty and health problems increase with age. Indeed, the prevalence of cancer increases among elderly population in general(Ershler and Longo, 1997). Cancer among elderly individuals may affect them in different ways. Some of the most dramatic changes experienced by elderly people having cancer include, as reported by(Zuniga, 1995), retirement, widowhood, change of living conditions, and health status. Rolland(1994) illustrated that when a couple is diagnosed with a serious condition, such as cancer, they react either by clinging in a fused way to each other or pulling away from one another. In some cultures, cancer is considered as a source of shame and stigma. According to Doka(1993), patients diagnosed with a life-threatening illness may suffer from stigmas which affect their identity, self-esteem, and interaction with others. Such stigmas are also experienced by patients once they have been diagnosed with cancer, including children(Sourkes, 1995). Alkhwaldeh(2002) conducted a study on 129 Jordanian female cancer patients. It was reported by 27% of respondents that society had a negative image about them once they were diagnosed with cancer. The study also found that 33% of respondents tried to hide their cancer diagnosis from others fearing stigmas. Fear of the stigma of being a cancer patient was also reported by most respondents in a study on 120 Jordanian females with breast cancer(Alassaf, 2009).

Indeed, the discussion with the focus groups and findings of previous studies support Durkheim's proposition that change in any of the parts of the social system would result in changes in other parts, and as such in the whole system. However, fast and unexpected changes, especially those causing stress or crises, may cause a disruption of the system which would call for individual and group adaptation and responses.

Being diagnosed with cancer has many effects on different dimensions of patients and the rest of their family members, regardless of the status of their life cycle. An individual's age at times of diagnosis is a significant determinant in the coping responses. For young children, having cancer usually affects their relationships with peers, activities with other family members, including brothers and sisters, poses major interruptions in the child's developmental stage, and negatively affects progress in school. Regarding young adults, for example, they face different set of challenges. Some of these challenges may include: establishing themselves in the world of work, setting-up a household, raising a family, and playing the role of parenting. On the other hand, the occurrence of cancer among elderly people at retirement age may have many reverse effects on their leisure activities, retirement savings, and an increasing chance of dealing with other chronic illnesses and disabilities. Even when a patient passes away as a result of cancer, the pain of the family may continue.

Many patients illustrated that having cancer not only affects their life and that of their families, but also affects other dimensions of their social life, including economic expenditures and social interaction with non family members, such as friends and relatives. A patient in his sixties stated:

Since I was diagnosed with cancer, I cried once in a while; became nervous, especially at the beginning of the diagnosis; separated myself from friends, neighbors, and relatives; quit my job; miss a lot my youngest daughter's activities, as well as I worry about her future; and think about my death which will not be too far. I hardly eat well, suffer from insomnia, and have financial difficulties, including the cost of covering transportation back and forth to the hospital since I live in another city; Irbid.

A female social worker who has many years experience working with cancer patients in a Jordanian hospitals recounted how the disease of cancer created different difficulties and disturbances in the lives of patients and their families. She stated:

In addition to the psycho-social and physical stresses cancer patients face during the stages of diagnosis and treatment, other external stresses and difficulties arise. These main difficulties include: missing attendance of teaching stations, such as schools and universities and sometimes on a temporary basis; financial difficulties related to transportation of patients, attendants of patients, friends and other family members between their original place of residence and the hospital; quitting a job or being forced to quit. This particularly happens if the treatment is length. Other difficulties include: having limited activities with friends, relatives, and the external environment; having less supervision on other family members, namely if the patient or the attendant is the mother; having difficulty to attend group prayers, specifically on Fridays; and for many patients, being confused and distressed with having to answer questions from their friends and relatives about their medical condition and treatment.

Proposition 3: Common Values and Reorganization of the System

The third functional proposition adopted by Durkheim is that common values play a positive role in the reorganization process of the disturbed social system. Durkheim(1961) indicated that religion, mainly in traditional societies, could be a strong source of social cohesion and integration, and that religious beliefs and values play a major role in explaining illness. Baum(2004) reported that the medicalization of cancer since its diagnosis prevents patients from receiving spiritual and moral support even though it is very important to look at patients' needs in relation to their spiritual and moral support. Errihani et al.(2008) conducted a study on 1600 adult male and female Moroccan cancer patients. Researchers found that even though all patients were Moslems, those who were practicing believers(practicing pillars of Islam) had more acceptance of their diagnosis with cancer than non-practicing believers. Practicing believers were found to believe that having cancer means a test by God for his believers and they were proud to be selected and tested by their God. Yet, such practices are not limited to Islamic patients. For example, a study by Alferi et al.(1999) on 49 Hispanic female cancer patients found that the more religious patients were, the less they were distressed.

Marital status could also be a significant factor in the time length of seeking diagnosis of disease, including cancer. A study by Thongsuksai et al.(2000) on Thai women, newly diagnosed with breast cancer, reported that married women have a shorter period of delay to be diagnosed than unmarried women. On the other hand, Patterson et al.(2004) found that 77% of parents of children with cancer used at least one way to think about their circumstances or give meaning to them as a method to manage their strain and difficulties. The most commonly reported ways included, from the most to the least commonly reported, being positive and maintaining hope, comparing their circumstances with others having similar experiences, trusting in God, focusing and living in the present, instead of thinking about the possibility of death to their child, denying what was happening, and seeing the good things in their experience.

Since Islam is the dominant religion in many countries worldwide, it is hard for any patient to think about suicide, simply because it is forbidden and its practitioners are seen as unbelievers. A cross-sectional study on 188 Turkish women having breast cancer found that religious coping, social support, problem focused coping, and optimistic coping had a positive relationship with their health related quality of life(Filazoglu and Griva, 2008). Data obtained from 71 female and male Jordanian cancer patients in three Jordanian hospitals found that basic coping strategies used by patients to respond to their disease included religion, positive interpretation of the disease, and acceptance(Al-Natsheh, 2000).

Family support system can also play a vital role in the life course of cancer patients and improve their health and well-being. Diane(2008) pointed out that cancer affects the lives of patients, their children, their partners, and their entire family system. Understanding such a relationship is important for providing adequate and appropriate psychosocial services to cancer patients and the rest of their family members. A study by Sanjari et al.(2008), on 120 adolescents in Iran between the ages of 11-18 years found that children who received support and belonged to families characterized by a strong social cohesion were more adaptive to their disease than others. Similarly, a research on 153 cancer patients and their partners found that their anger expression styles usually modify the atmosphere of the family, and combined, they determine the long-term quality of life for patients. The study also concluded that for cancer patients, family members are the most valuable source of social support for cancer patients(Julkunen et al., 2009). A social worker who has many years of experience working with cancer patients in a private Jordanian hospital commented from a focus group discussion:

Many patients become more religious since they know that they have cancer. This usually applies to the other family members as well. Some patients who used not to perform prayers started to perform it on a regular basis. They started to read more from the Koran. I believe becoming religious or more religious provides patients and their family members more psychological comfort and relief.

In conclusion, the preceding discussion is supportive of Durkheim's explanation that man and social groups try to adapt to new conditions, including stress, crises, and disturbances in different ways. These ways are usually chosen according to the dominant culture, and in the case of the individual, according to the type of personality, which, as illustrated by Durkheim, is shaped by the common and dominant cultural system of the group.

Second: Limitations of Durkheim's Functionalism

Durkheim's functional theory was strong enough in providing theoretical explanations that are capable in explaining the process of social interaction between patients and their families and the cancer disease. Conversely, Durkheim's theory faces many limitations in providing theoretical explanations related to the coping processes of patients and their family members with cancer. Some of these limitations are related to the ignorance of psychological factors, underestimating structural changes, lessening the different effects of economic factors, and legitimizing gender differences.

Underestimating Psychological Factors

Durkheim was a functional theorist where his analyses are macro oriented since he focused on societal factors(the macro level) and ignored psychological factors(the micro level). Certainly, Durkheim(1982, P. 123) strongly believed that "social factors" are the subject matter of sociology and defined social factors as: "which is general over the whole of a given society whilst having an existence of its own, independent of its individual manifestations." For example, in his study of suicide, he tried to use empirical data to prove that social factors can only be explained by other social factors and not by psychological factors(Durkheim, 1951).

A review of the previous literature showed how the process of being diagnosed with cancer has many psychological consequences on both patients and their families. Farkas(1980) pointed out that the spouse of a chronically ill person experiences a wide range of reactions, such as anxiety, helplessness, anger, blame, sadness, fear, depression, and shame. A study by Zachariae et al.(2004) on women diagnosed with breast cancer in Denmark found repressive coping among respondents to be higher after diagnosis. Researchers defined repressive coping as "having high scores on defensiveness and low scores on anxiety."(P. 547). The study also found that only the variables of having biological children, repressive coping before diagnosis, and cancer diagnosis are associated with repressive coping four weeks after being diagnosed with cancer. However, twelve weeks after the diagnosis, only the age variable was associated with repressive coping. On the contrary, some independent variables were associated with repression after diagnosis, including educational level, employment status, and number of relatives who died from or survived breast cancer. These findings supported previous conclusions by Kreitler et al.(1993) who found higher repression coping among women diagnosed with breast cancer in comparison with women without having cancer. Gorzynski and Holland(1979) found that young adults diagnosed with non-seminomatous testicular cancer may delay seeking treatment due to ignorance or denial, fear about sexual functioning, depression, and increased anxiety accompanying the cessation of treatment.

While some studies found a higher risk of developing cancer in the future among people repressing their emotions(Duszynski et al., 1981), other studies did not find such a relationship(Shekelle et al., 1981; Persky et al., 1987). Findings from other research investigations also indicated that fathers, at diagnosis of their children with cancer, most commonly coped in a practical way or used emotional withdrawal, while mothers coped most commonly through emotional release(Mastroy-annopoulou et al., 1997). Abu-Albasal(2006) conducted a study on 144 male and female cancer patients at Al-Bashir Hospital in Jordan. All respondents were between the ages of 20-78 years old. The study found higher levels of depression and anxiety among married respondents than among non-married. Depression and anxiety were also found to be higher among female than male patients. A female social worker who had been working at Al-Hussein Cancer Center for more than seven years stated:

One of the most painful experiences for me is the reaction of patients and their family members when they know about their patient being diagnosed with cancer. For most patients and their families, this moment represents a psychological death.

Underestimating Structural Changes

Functionalists, such as Durkheim, overemphasize the functional advantages of conservative social concepts such as harmony, equilibrium, and the integration of different social systems. Moreover, they consider structural changes as dysfunctional and usually bring undesirable effects and consequences, particularly unexpected ones(Sanderson, 1988). However, many groups are located in the bottom of the social stratification system of any given society. This gave different social groups more or less advantages from the existing social status. For example, wealthy people have the best social insurance system and may seek treatment in the best equipped medical stations and hospitals inside or outside the country.

In Jordan, for example, there are thousands of people who have no medical insurance system. Indeed, many researchers illustrated how the absence of medical insurance is one of the basic factors behind not seeking medical diagnosis at an early stage when experiencing ailments and pain(Cockerham, 1995; Dhooper, 1998). Moreover, most hospitals specializing in cancer are concentrated in Amman, the capital of Jordan. Furthermore, there is an absence of any policy or legislation that may force medical stations to employ medical social workers and psychiatrists to provide psycho-social support for patients and their family members.

Lessening the Effects of Economic Factors:

Worldwide, people belonging to lower social classes are usually less healthy than others. On the other hand, rich and wealthy people eat more nutritious food, work in safer environments, reside in healthier homes and locations, have more access to medical facilities, and have longer life-expectancies(Macionis, 1997). A study found that in Colorado, USA, poverty was an important factor,

which increased the risk of getting cancer at a later stage, and dying from cancer (Colorado Department of Public Health and Environment, 2008).

It was reported by Loerzel and Busby (2005) that individuals with low socio-economic status are more likely to be diagnosed at a later stage of cancer than others who undergo regular screening tests. Individuals with low socio-economic status are also less likely to adhere to recommended cancer screening tests. A survey study conducted on 65,192 cancer patients in Britain (Neal and Allgar, 2005) found that people belonging to lower social class groups had longer delays in diagnosis than other groups because of many factors. Some of these factors included having limited information about the symptoms of the disease and limited access to medical services. A study on women surviving breast cancer in the United States showed a strong positive association between poverty level and a breast cancer diagnosis, particularly among African American women in the areas of Detroit and Atlanta (Schootman et al., 2009). Research by Augustson et al. (2003) on a sample of 862 low-income women, mostly African Americans, found that women who had a regular physician and those with higher educational levels were more likely to adhere to and comply with screening guidelines for cervical and breast cancer.

A 57 year old male, who had been hospitalized for three months at Al-Bashir Hospital for treatment of breast cancer and who is currently in the fourth stage of disease where cancer spread to the marrow of the bone stated:

I was working in a private business to secure some income in addition to my limited income from the social security, since I am a retired teacher. I am married and have five children; three daughters and two sons. I quit my business because of my unexpected disease. Now my family has a very tough financial situation because all of them are dependent on me. Sometimes my family cannot secure basic needs, including food and school expenses. I feel very sorry for my youngest son who is currently in grade ten. I am also worried about his future in terms of who will cover his educational cost especially after completing high school. When I remember the situation of my family, all I do is cry, but I have to submit things to God.

Indeed, since the treatment of cancer is free in Jordan, many patients in Jordanian hospitals come from other Arab countries and some are not covered by any medical insurance. Even when covered by medical insurance, other required expenses, such as transportation, calls for other family members, as well as residence and food for some accompanying family members, could be painful for patients and their families, mainly poor ones. Responses provided by patients and their family members who participated in the focus groups discussions showed how economic factors are important and affect their life in the case of having cancer. A lady from Palestine who accompanied her 9 years old daughter afflicted with cancer stated:

The medical cost of treatment for my daughter is very stressful for my family. Even though we have medical insurance, the only income we have is my husband's salary, which is limited. Since my daughter got sick, my brothers-in-law are sending us money to cover some of our expenses. Our expenses have rapidly increased after my daughter's diagnosis.

A 58 year old male, hospitalized in a private hospital, from another neighboring Arab country and getting treatment for leukemia illustrated:

For 18 months, I had to come to Amman on a regular basis in order to get treatment for my leukemia. I am covered by medical insurance, but it does not cover non-medical needs. My wife accompanied me during that time. At the beginning of my treatment, she took leave from her work as a teacher without salary. When she tried to extend her leave, her school refused, she was forced to resign. Now we rent an apartment for 250 J.D.'s a month in Amman. I sold a piece of land in my country to cover our expenses. One of my sons is engaged, but we had to spend all the money he saved to cover his future marriage expenses. None of my children were able to visit me at the hospital because they do not have money to spend on their travel and other expenses while being in Jordan.

Legitimizing Gender Differences:

Most classical functionalists considered gender differences and expected roles as normal and important because they fulfill some social functions. Gender differences are created by the system of the division of labor in any given society. Indeed, Durkheim did not consider gender as a unit of analysis in his sociological writings. Conversely, Durkheim (1964) believed that gender differences are not social

differences but natural ones, which are realized through practice. However, Adair(2008, P. 100) stated that “Durkheim has not been sociological enough, in that by naturalizing inequalities, he fails to consider the social distinctions that rank hierarchies and distribute valuations, privileges, and honors.” Many sociologists, such as Spelman(1997) believed that gender identity cannot be understood in terms of individual’s biological or psychological states, but in terms of the imposition of the classification system. Most feminists believed that since feminism aims to increase the autonomy of women in society, then Durkheim is clearly understood, seen, and classified as an antifeminist sociologist(Lamanna, 2002).

The Jordanian family system, as well as other Arab societies, is a patriarchal one(Abu Househ, 2001; Dwairy, 1998). As a result, reaction to the diagnosis and treatment of the cancer disease differs by the gender of both the diagnosed patients and that of other family members. For example, mothers react with more depression than fathers to the diagnosis of their children with cancer(Sawyer et al., 1993). In fact, mothers of children diagnosed with and/or treated for cancer reacted with more sadness, anxiety, physical complaints(Hoekstra-Weebers et al., 1998) or experienced more psychiatric difficulties than fathers(Brown *et al.*, 1993). In addition, a study by Larson et al.(1994) found engaged coping styles were used by mothers more than fathers.

Verbrugge(1985) concluded that women were found to prefer more tension-reducing and problem solving, as well as more active coping behavior than men did. On the contrary, women were found to prefer to use more emotion-focused and social support styles than men do. However, a study by Porter and Stone(1995) showed no such gender differences. This shows how culture imposes more pressure on mothers than fathers to take care of the health of other family members. On the other hand, society, mainly in developing and traditional societies, value males more than females. This implies that the family may care more about its male patients than females.

Alkhwaldh(2002) study on female cancer patients in Jordan found that most had experienced difficulty in meeting their expected familial roles. These difficulties related to familial role expectations are reported in a study on 120 females with breast cancer in Jordan(Alassaf, 2009). A female social worker who has worked in a private Jordanian hospital for many years stated:

Almost all attendants of infants and children are their mothers. Mothers suffer from many pressures. Some of these pressures include: anger from the other children and infants toward their mother because she spends most of her time with the patient child, pressure from parents of the husband because they usually take care of other children at home, fear from being disposed from the her work in which they have to obtain false medical reports in order not to lose their jobs, difficulties in meeting their home obligations along with needs of the infected child. Indeed, some of the husbands of these mothers divorced them under the justification that they did not meet their familial roles, including preparing meals and taking care of their other children. Under such psychosocial pressures, some of the mothers, in turn, revenge from their patient children, such as abusing them physically, emotionally, and verbally. Indeed, many of these mothers wished death for their patient children and made this wish in front of their patient children.

Generally, Durkheim was not successful in establishing a social theory that is capable in explaining gender differences, including their familial and societal positions and roles. This was a main critique directed to Durkheim by many thinkers who believed that Durkheim did not provide an adequate social theory explaining social inequalities on the basis of gender(Bottomore, 1981; Lehmann, 1995; Lockwood, 1992; Zeitlin, 2001).

Discussion of Findings

The study concluded that the classical functional theory cannot provide a full explanation of social world. This reflects the fact that any social theory, including functionalism, has its strengths and weaknesses. This was also true for Durkheim’s functional approach in which this study illustrated that he provided some strong propositions that can explain the coping process of patients and their families to cancer disease. On the other hand, he failed to provide theoretical assumptions considering, for example, psychological factors and gender differences and inequalities

The study concluded that there are many factors that influence individual and family responses or coping processes to the cancer disease. The most reported factors include age, gender, socio-economic status, coping style, family functioning system, religion, and culture. In fact, all these factors are interrelated and have a mutual relationship. This interrelatedness of the preceding factors is enhanced by previous field research on the subject (Mechanic, 1978; Neal and Allgar, 2005).

Cultural norms, customs, and value system affect therapist techniques. For example, current techniques of therapy in the United States are derived from Western cultures that emphasize directness, individuality, independence, and verbal expressions (Cook and Dworkin, 1992, P.154). Sourkes (1995) indicated that considerations about what or how much to tell a child with a life-threatening illness include: the child's age at diagnosis, emotional and cognitive maturity, cultural background, family structure and functioning, and history of loss.

Adams (1992) reported that social workers who work with children in hospitals can provide a full range of counseling services including helping children and their families by providing information or referral to community resources. Social workers in hospitals can play a vital role, such as referring patients and/or their family members to community resources, lessening economic pressures on patients and their families in different means, such as securing a job for an unemployed family member, helping patients to adapt to the hospital's environment, and changing patients' negative image toward their ailments and diseases (Darwish and Masoud, 2004). Unfortunately, most Jordanian hospitals do not have social workers or psychiatrists who may help patients and their family members with psycho-social support. A study by Zaidan (2000) conducted an experimental study on 20 families with children getting treatment for cancer from different Egyptian hospitals. The study exposed parents of children, who were chosen through a purposive sample, to a counseling program that proved to be successful in reducing anxiety between both parents. Almost all social workers who participated in this study pointed out that there is no mutual support and feedback among different hospitals in relation to the role of social work in dealing with cancer patients.

Conclusion

This study showed that even though the functional approach is one of the most dominant schools in contemporary social literature, it has both strengths and weaknesses, as presented by Durkheim, in explaining social interaction and social phenomena. In the case of coping styles and factors affecting responses of patients and their family members to the diagnostic stage of cancer, some propositions had provided effective explanations and others have failed to provide such explanations. Effective and supportive propositions include: the interrelatedness of the different parts of the social system, change in any parts or sub-systems may create imbalance in other systems, and the role of common values in reorganizing the social system. On the other hand, some findings and practical evidence did not have any theoretical explanations by Durkheim. As a result, his theoretical explanations neglected psychological causes, symptoms, and effects of social interaction, underestimated macro changes, lessened the positive functional consequences of macro economic factors, and legitimized gender differences in society.

Recommendations

Many recommendations are provided to reduce the negative effects and consequences of cancer on patients and their families of procreation or orientation:

1. Launching and intensifying awareness campaigns that target medical staff, mainly physicians including oncologists, to value the effects of psycho-social factors on patients and their families. Physicians should also realize and consider the role of social workers and psychiatrists in hospitals and work with them as part of a medical team that aims for the ultimate well being and health of patients and their families.
2. Increasing the numbers of qualified medical social workers and psychiatrists in hospitals and clinics that deal with cancer disease and other life-threatening illnesses. Having and implementing legislation by the Jordanian Ministry of Health that obligates hospitals to recruit and provide job descriptions for social workers and psychiatrists is a priority.

3. Networking among different Jordanian hospitals in relation to psychosocial support for patients with cancer and their families. This is important since many social workers reported that such networking is almost absent in Jordanian hospitals.
4. Conducting more field research by the use of empirical data in order to examine to which extent other social theories can explain coping skills of parents and their families with cancer.

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they enact. This study compared family functioning and coping styles within and between 2 different medical groups: families of children with cancer (n = 44) and HIV disease (n = 65). Most caregivers reported healthy family functioning, and no between-group differences in functioning emerged.Â functioning and coping of the family as a unit, rather than at the level of its individual members. We sought.Â All eligible caregivers of 44 pediatric patients with cancer and 65 pediatric patients with vertically acquired HIV disease participated in the current study. Patients were. Patients with peripheral artery disease have a marked reduction in exercise performance and daily ambulatory activity irrespective of their limb symptoms of classic or atypical claudication. This r...Â The underlying mechanisms responsible for the functional limitations in PAD are hemodynamic in origin, which affects the supply of oxygen and substrates to metabolically active tissue: skeletal muscle in the case of intermittent claudication and skin and subcutaneous tissues in the case of critical leg ischemia.Â In a large cohort of patients from the Edinburgh Artery Study, blood viscosity and fibrinogen were independently associated with hemodynamic disease severity of PAD, and fibrin degradation products were also associated with progression of PAD.

Background: The 2019 coronavirus disease (COVID-19) epidemic is a public health emergency of international concern and poses a challenge to psychological resilience. Research data are needed to develop evidence-driven strategies to reduce adverse psychological impacts and psychiatric symptoms during the epidemic. The aim of this study was to survey the general public in China to better understand their levels of psychological impact, anxiety, depression, and stress during the initial stage of the COVID-19 outbreak. The data will be used for future reference.

Methods: From 31 January to 2 Febru