LOGOTHERAPY AND COGNITIVE REFRAMING IN THE MANAGEMENT OF BLAME ATTRIBUTION AMONG NEWLY DIAGNOSED CANCER PATIENTS IN SOUTHWESTERN NIGERIA

BY

Shakirat Bolanle IBITOYE

B.Ed, M.Ed (Ibadan)

MATRIC NO: 167222

A Thesis in the Department of Counselling and Human Development Studies
Submitted to the Faculty of Education
In partial fulfillment of the requirements for the award of Degree of

DOCTOR OF PHILOSOPHY (Ph.D)

of the

UNIVERSITY OF IBADAN

CERTIFICATION

I certify that this work was carried out under my supervision by **Shakirat Bolanle IBITOYE (Matric Number: 167222)** in the Department of Counselling and Human Development Studies, Faculty of Education, University of Ibadan, Ibadan.

……………………………………………………………………

SUPERVISOR

Prof. Chioma C. Asuzu

Department of Counselling and Human Development Studies, University of Ibadan, Ibadan, Nigeria.

DEDICATION

This study is dedicated to the loving memory of my late dad, Alhaji Najeem A. Jimoh. Thank you for leaving a good legacy and for setting a solid, sound and strong educational foundation for my siblings and I.

To my dear husband, Mr. Kazeem Gbolagade Ibitoye and my adorable children; Fareedah Folakemi, Farouq Folakunmi and Fadhlullah Folaranmi Ibitoye, I appreciate you all.

ACKNOWLEDGEMENTS

My profound appreciation to Almighty Allah for granting me the grace from the beginning of the programme and for His mercy, protection and provision throughout the journey.

I have enjoyed the rare privilege of working closely with my amiable supervisor, Professor Chioma C. Asuzu, a mother in the true sense of the word for her mentorship, love, time, attention, support and for guiding me throughout the programme. She has been a great teacher and a pillar who spared nothing to ensure a hitch-free Ph.D journey. I appreciate your support, contributions, interest and sacrifice all the way. You are a rare gem ma!

I appreciate the involvement of all the dedicated lecturers in the Department of Counselling and Human Development Studies, University of Ibadan for impacting in me. I acknowledge their contributions, support and encouragement during the programme. Professors C.B.U. Uwakwe, A.O. Falaye, D.A. Adeyemo, O.A. Aremu, T.A. Hammed, A.E. Awoyemi, R.A Animasahun, Drs. D.A. Oluwole, M.O. Ogundokun, A.M. Jimoh, J.O. Fehintola, A.A. Owodunni, A.O. Adeyemi, N.M. Ofole, A.K. Taiwo, A.O. Oyekola, S.A. Odedokun and O. Akinyemi, thank you all for contributing positively to the success of this work. Late Professor J.O. Osiki and Drs. A.O. Busari and O. B. Oparah, may your gentle souls continue to rest in peace. Thank you for your invaluable contributions towards the success of this programme. To Drs. A.K. Taiwo and D.A. Oluwole who both served in the capacities of sub-dean postgraduate and Ph.D coordinator respectively, your labour of love did not go unnoticed, you are highly appreciated.

I acknowledge the support of the ethics committees and the oncology units, University College Hospital, Ibadan, Federal Medical Centre, Abeokuta and Lagos University Teaching Hospital for supporting the study and for ensuring prompt review and approval of the proposals. I say a special thank you to Drs. Ntekim Atara and Elizabeth Akin-Odanye and Mrs Omolara Fagbenle, all of the University College Hospital, Ibadan for their contributions, suggestions and support. I am indeed grateful to Drs. Muhammed Habeebu and Akeem Adeniji of Lagos University Teaching Hospital; Drs. Fadimu, Nkom, Adebanjo and Abdulrazaq, Mrs Adeseni, Mrs Adewumi, Mrs Olumade, Mrs Osi, Mr Enitan, Miss Abimbola and Timileyin all of the Federal Medical

Centre, Abeokuta for providing an enabling environment for recruitment of the study participants. Thank you for being supportive and for the cooperation and encouragement I enjoyed during the recruitment, data collection and intervention stages.

My appreciation also goes to all the participants in the study for their strength and willingness to participate in the study. I appreciate their courage to share their experiences and stories which were of immense contributions to the success of the study.

I thank my mother, Alhaja Rafat A. Jimoh for her motherly and financial support, generosity and encouragement throughout and for taking care of my kids whenever the need arose. Also, I appreciate my siblings for their support, encouragement, interest and contributions both morally and financially. I am most grateful.

I appreciate my friend and sister Dr. Sophia Vivian Adeyeye for being a pillar of support and encouragement throughout this journey. I will forever be grateful to all my friends and colleagues in the department for their immense contributions during the study and to all the non-teaching staff of the department, I say thank you. My appreciation also goes to Alhaji A.A. Olasupo, Mrs O.T. Kalesanwo, Barrister A.O. Oduola and Alhaji Haroun A. Lawal for providing an enabling environment at the work place during the periods I served under their leadership at different times. To my amiable typist, Alhaja Fatima Aminu, thank you for your unending prayers, support and professional input throughout this study.

I sincerely appreciate my loving husband, Mr. Kazeem Ibitoye for the continuous encouragement and unfailing support throughout the journey and at all times. Words cannot describe the emotional, moral, financial and spiritual support I enjoyed during the programme. Thank you for being considerate and for believing in me. Thank you for the perseverance and unending patience, without these, this feat would not have been achieved. And to my adorable children: Fareedah, Farouq and Fadhlullah, I appreciate your understanding, love, support, prayers and perseverance. I am indebted to you all for being wonderful cheer leaders. You didn’t make me regret the decision of embarking on this journey. I love you all.

ABSTRACT

Blame attribution is a situation whereby patients apportion blame of the cause of their illness to themselves, the environment, significant others and illogical factors. The negative effects of this behaviour on newly diagnosed cancer patients include poor prognosis and management of the disease. Previous studies focused largely on psychological and social factors influencing blame attribution, with little emphasis on therapeutic interventions through the use of logotherapy and cognitive reframing. However, many newly diagnosed cancer patients in southwestern Nigeria are deficient in the management of blame attribution, which often results in emotional distress and failure to adhere to orthodox form of treatment. This study, therefore, was carried out to determine the effects of Logotherapy (LT) and Cognitive Reframing (CR) in the management of blame attribution among newly diagnosed cancer patients in southwestern Nigeria. The moderating effects of health self-efficacy and social support were also examined.

The study was anchored to the Health Belief Model, while the pretest-posttest control group quasi-experimental design with a 3x2x2 factorial matrix was adopted. Three states (Oyo, Lagos and Ogun) with cancer treatment centres (University College Hospital, Ibadan; Lagos University Teaching Hospital, Lagos and Federal Medical Centre, Abeokuta) respectively in southwestern Nigeria were purposively selected. The Blame Attribution Questionnaire (α=0.81) was used for screening. Fifty-four cancer patients who scored high on the Blame Attribution Screening tool were selected. The participants were randomly assigned to LT (18), CR (21) and control (15) groups. The instruments used were Modified Attributions for Illness (α=0.85), Health Self-Efficacy (α=0.84) and Medical Outcomes Survey Social Support (α=0.89) scales. Treatment lasted eight weeks. Data were analysed using descriptive statistics, Analysis of covariance and Scheffe post-hoc test at 0.05 level of significance.

Participants' average age was 53.85±7.89 years and they were mostly females (88.9%). Types of cancer participants suffer from were breast cancer (53.7%), cervical cancer (33.3%), prostate cancer (9.3%) and skin cancer (3.7%). There was a significant main effect of treatment on blame attribution among the participants ($F_{(2;42)}$ = 16.03; partial η^2 = 0.43). The participants in the CR ($\bar{x}$= 42.91) benefitted more than those in the LT ($\bar{x}$= 63.56) and the control ($\bar{x}$= 66.87) groups. There was a significant main effect of health self-efficacy ($F_{(1;42)}$ = 6.09; partial η^2 = 0.13) on blame attribution. The participants with high health self-efficacy had a lower post-mean score on blame attribution (43.22) compared to those with low health self-efficacy (69.67). There was a significant main effect of social support ($F_{(1;42)}$= 24.77; partial η^2 = 0.37) on blame attribution. The participants with high social support ($\bar{x}$ = 43.65) benefitted more than those with low social support ($\bar{x}$= 71.28). The two-way and three-way interaction effects were not significant.

Logotherapy and cognitive reframing were effective in managing blame attribution among newly diagnosed cancer patients in southwestern Nigeria with particular attention to health self-efficacy and social support. Counselling and clinical psychologists should adopt these therapies in managing blame attribution among newly diagnosed cancer patients.

Keywords: Blame attribution, Logotherapy and Cognitive reframing, Cancer patient's management, Health Self-efficacy, Social support

Word count: 486

TABLE OF CONTENTS

Title Page	i
Certification	ii
Dedication	iii
Acknowledgements	iv
Abstract	vi
Table of Contents	vii
List of Tables	x
List of Figures	xi

CHAPTER ONE: INTRODUCTION

1.1	Background to the study	1
1.2	Statement of the Problem	11
1.3	Objectives of the Study	13
1.4	Hypotheses	13
1.5	Significance of the Study	14
1.6	Scope of the Study	16
1.7	Operational Definition of Terms	16

CHAPTER TWO: LITERATURE REVIEW

2.1	Conceptual Review of Literature	17
2.1.1	Concept of Blame Attribution	17
2.1.2	Concept of Cancer Disease	27
2.1.3	Concept of Logotherapy and its Components	34
2.1.4	Concept of Cognitive Reframing	41
2.1.5	Concept of Social Support	46
2.1.6	Concept of Self-Efficacy	51
2.1.7	Health Self-Efficacy	54
2.2	Theoretical Framework	57
2.2.1	Theory of Blame Attribution	57
2.2.2	Mao and Gratch Computational Model of Attribution	59
2.2.3	Theory of Reasoned Action	61

2.2.4 The Health Belief Model 61
2.3 Empirical Review of Literature 64
2.3.1 Blame Attribution and Cancer 64
2.3.2 Logotherapy and Blame Attribution among Cancer Patients 70
2.3.3 Cognitive Reframing and Blame Attribution among Cancer Patients 76
2.3.4 Social Support and Blame Attribution among Cancer Patients 80
2.3.5 Health Self-Efficacy and Blame Attribution among Cancer Patients 88
2.4 Conceptual Model for the Study 92

CHAPTER THREE: METHODOLOGY
3.1 Design 94
3.2 Population 94
3.3 Sample and Sampling Technique 95
3.4 Inclusion Criteria 97
3.5 Instrumentation 97
3.6 Procedure for Data Collection 100
3.7 Treatment Manuals 102
3.8 Control of Extraneous Variables 139
3.9 Data Analysis 139

CHAPTER FOUR:
RESULTS, INTERPRETATION AND DISCUSSION OF FINDINGS
4.1 Data Analysis and Results 140
4.2 Summary of Findings 148
4.3 Discussion of Findings 148

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS
5.1 Conclusion 158
5.2 Implications of Findings 159
5.3 Recommendations 160
5.4 Contribution to knowledge 161
5.5 Limitations of the Study 162

5.6 Suggestions for Further Studies 163
References 164
Appendix I (Instruments) 193
Appendix II (Informed Consent Form) 199
Appendix III (Yoruba version of Instrument, ICF and Treatment Manual) 202
Appendix IV (Ethical Approval Letters) 246
Appendix V (Pictures) 249

LIST OF TABLES

Table 3.1 Factorial Matrix for the Study 94

Table 4.1 Distribution of Participants' Demographics 144

Table 4.2 Summary of Analysis of covariance (ANCOVA) showing the main and interaction effects of the intervention groups, health self-efficacy and social support on Blame Attribution among the participants 145

Table 4.3 Summary of Scheffe Post-Hoc Analysis showing significant differences in the treatment and control groups 146

Table 4.4 Multiple Classification Analysis showing the direction of differences among the treatment and control groups; health self-efficacy and social support towards managing blame attribution among newly diagnosed cancer patients 147

LIST OF FIGURES

Figure 2.1 Prevalence of Cancer in Nigeria 33

Figure 2.2 Conceptual Model for the Study 92

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Cancer diagnosis is the process of identifying that an individual has the condition from its signs, symptoms and confirmation through physical examination, blood tests, imaging tests, biopsy, immunohistochemistry, tumour markers and histology reports. The period following diagnosis has been identified as the most difficult for cancer patients to handle because it is a period characterized by a feeling of betrayal by their bodies, particularly if they think they had been doing 'the right things'. Patients newly diagnosed with cancer usually ask the question: "Why?" Patients may feel a sense of self-punishment and want to know what has been done or not done that may lead to the diagnosis. Some patients often feel that lifestyle choices may be the cause of diagnosis. Genetic factors may play a part in the course in which the patient believes that the condition has been inherited.

The "Why?" question may be mental or spiritual in nature. Patients react in diverse ways to the information of carrying a potentially fatal illness like cancer. Generally, nearly every patient goes through different stages when the diagnosis of a disease like cancer occurs. These include felings of disbelief, anxiety, shock, fear, despair, anger, guilt feeling and depression (Kantor, 2016). Being diagnosed with cancer leads to a myriad of challenges that may have negative psychological impacts on the patients making the patients feel depressed, develop emotional instability, deny the diagnosis and get angry (Iddrisu, Aziato and Dedey, 2020).

The initial response to cancer diagnosis is usually characterised by shock and denial, followed by a period of distress, characterized by a mixture of anxiety, anger and sometimes depression. Cancer diagnosis can lead to continuous grief, fear, worry, denial, loneliness, reduced interest in sexual activity, loss of appetite and weight, fatigue, lack of concentration, difficulty remembering or making decisions, insomnia and restlessness. Other common sensations may include withdrawal, avoidance, blame, loss of control,

isolation, loss of dignity, despair, loss of meaning, low morale and physical symptoms (National Cancer Institute, 2018).

The human nature has the tendency to attribute blame to something or someone for an unpleasant incident, thereby projecting a justification for their actions and events experienced by them (Banerjee, Gidwani and Sathyanarayana, 2020). Being diagnosed with any form of cancer is likely to be frightening, and it often springs up a wide range of difficult emotions that may significantly affect many areas of a person's life negatively. In clinical settings, it is common to see newly diagnosed cancer patients attributing the cause of the ailment to people and even to non-medical causes. Some patients may even go as far as giving the disease other names different from cancer just because they do not agree with the medical view about the disease. These beliefs go a long way in affecting the patients as other alternatives may be sought for cure rather than embracing orthodox treatment. The implication of this action is that a lot of time, money and efforts would be wasted and by the time the patient decides to seek medical help, the disease may have progressed to an advanced stage thereby impeding the progress of treatment and making prognosis more dangerous. This is a major reason some cancer patients present symptoms at the advanced stage of the disease. In some cases, a patient may attend medical facilities for treatment but may not adhere to treatment plans due to the beliefs held about the disease.

Blame attribution is an old construct peculiar to humanity. Assigning blame in a situation goes a long way in determining the resulting response to such situation which is evident in behaviours of individuals facing such situations (Hochlaf, Quilter-Pinner and Kibasi, 2019). Some patients may attribute the cancer to themselves and the activities they had previously engaged in, the environment or to significant others around them. This may make the cancer patients feel anxious, depressed and distressed. It may also lead to isolation and in the quest to search for the cause of the disease, patients may begin to attribute blame to people and things. This usually prevents the patient from taking appropriate steps towards the management of the disease and it usually impedes the progress of treatment (Asuzu and Akin- Odanye, 2015).

Cancer is associated with significantly elevated morbidity and mortality (Ferlay *et al.*, 2020). As a result, the diagnosis of any form of cancer remains a bitter pill to

swallow, is considered by many to be a death sentence and its psychological effects are considerable. Having negative thoughts and feelings from the start is a natural reaction to a difficult situation because it is often difficult to accept or cope with the diagnosis immediately. However, considerable adjustments will be needed to properly manage the disease. According to Gorman (2018), the anxiety and uncertainty associated with a cancer diagnosis can cause psychosocial issues in all stages of cancer, can create extreme disruption in the life of almost any individual, can create a threat to an individual's general sense of security and many people retain deep-seated fears that all types of cancer represent pain, suffering, and death.

Cancer is a disease in which most people are scared and uncertain about the treatment regimen, its side effects and likely effect of the disease on the family and the work of the affected person. Many people seem uninformed and indifferent to the cancerous disease fuelled by the silent nature of the disease at an early stage. Cancer can be threating to a person's lifestyle, and the shock of diagnosis can be attributed to the fact that most people have a misperception of the nature of the disease and its progression. This is supported by Asuzu, Elumelu-Kupoluyi, Asuzu, Campbell, Akin-Odanye *et al.* (2015), who asserted that about 66% of the patients that attend the Radiotherapy Clinic at University College Hospital in Ibadan presented themselves in stages 3 and 4 of advanced disease and over two-thirds of these patients have diseases that have metastasized with a very poor prognosis. Presentating late at the clinic and the resulting poor prognosis are at the root of the lack of faith in the orthodox health system about the remedies that patients still want, even after arriving late in the hospital.

Several studies have proven that most patients with cancer are unaware of the nature and symptoms of cancer (Clegg-Lamptey, Dakubo and Attobra, 2009, Osime and Dongo, 2002) as a common reason for their late hospitalization and search for cancer cure in alternative treatment and failure to adhere to some form of orthodox treatment. Invariably, most people present symptoms at an advanced stage of the disease, which in most situations can lead to death. As a result, the information most often attributed to cancer is that it is a terminal illness and no one lives long with a cancer diagnosis.

Awareness campaigns and cancer sensitisation programmes are beginning to lead to a better understanding of cancer, but this has not changed people's attitudes towards

their diagnosis. The reason is that most newly diagnosed cancer patients find it disheartening to cope with the diagnosis and, at the same time, those affected want to make an extra effort to seek accelerated treatment for the disease. Attributing cancer to non-medical causes often results in decreased treatment and recovery. It can also lead to a high mortality rate as the disease progresses to a stage where the prognosis can become dangerous. More often, the metastatic nature of the cancerous disease makes delayed treatment, or even suspension of orthodox treatment, dangerous for patients, which may become fatal (Asuzu *et al.*, 2015).

A healthy emotional response to a cancer diagnosis therefore includes the initial reaction, distress and then adjustment. However, further feelings of hopelessness, guilt and blame attribution may indicate more serious psychological distress. The problem of blame attribution on public health and the society cannot be brushed aside as it negatively affects the efforts of the government and all the measures put in place in health sectors. When patients refuse to assess cancer treatment as a result of attributing blame, it leads to a waste of funds and resources already put in place by the government for management of cancer.

A lot of people cope with the diagnosis of cancer in different ways ranging from positive to negative. In some cases, the patient may decide to take the news with some form of strength and this consequently leads to effective coping styles, proper adjustment, adherence to treatment and proper management of the illness. Some patients may cope with the situation by concentrating on the things they can control, such as taking good care of their body and by maintaining a healthy diet. On the other hand, when a patient refuses to come to terms with the diagnosis of cancer or decides to apportion blame to people or things in the environment, a lot of time, energy and resources would be wasted and it may be difficult for such an individual to face reality of the presence of the disease and adjust considerably in order to manage the disease well. An individual, in a failure to cope with a cancer diagnosis may develop other life-threatening diseases such as high blood pressure or psychological disorders such as depression because he or she has refused to accept the diagnosis and has been non-adherent to medical treatment.

A lot of information is available on the social media especially with regards to causes of cancer and alternative cure for cancer. Cancer patients are responsible for

where and how they want to access treatment for their illness based on the beliefs they hold onto concerning the illness. A misinformed patient will adhere to any information he or she gets and this will contribute to a lot of factors which include how and where to go for treatment. Sarimiye (2019) asserted that cancer patients attribute the cause of the disease to ‘village people’ being responsible for the ailment and how they were ‘ready to fight back in the unconventional way’. A lot of cancer patients believe that orthodox medicine will not be capable of solving the dreadful disease. It is believed to be a ‘spiritual matter’ that needed a ‘spiritual solution’.

Due to blame attribution, many cancer patients may visit traditional therapists before and after going to orthodox medical institutions, especially when accepting unpleasant cancer diagnosis and uncomfortable treatment options. Some people don't even mind going to the hospital until the situation becomes very desperate (Asuzu *et al.*, 2015). In the Yoruba speaking part of southwestern Nigeria, the perception of disease is concentrated on natural, supernatural and mystical causes. These often affect people's beliefs and attitudes about specific health care outcomes and always influence the choice of specific health care services (Oke, 1995). There is a general belief among Yorubas in southwestern Nigeria that each person has at least one opponent who wants an evil and may expose a person to varying degrees of misfortune (Adamo, 1999). Therefore, when a tragedy strikes in the form of a strange illness or other unexplained negative life events, traditionalists or faith-based therapists are often asked to explain the causes of such incidents and provide remedies. There is not much understanding of cancer as a disease, and the diagnosis of this disease often leads many people to seek a second opinion in an unorthodox hospital, because people usually think this may be a "spiritual attack." The reason for seeking a second opinion may be that some patients stop accepting orthodox therapy or completely abandon it due to concerns about surgery or concerns about treatment side effects (Asuzu *et al*., 2015).

Most women in Sub-Saharan Africa seek traditional medicine and/or alternative treatments first and only report to hospitals when their breast cancer symptoms have worsened because traditional medicine is considered affordable, readily accessible, trustworthy and holistic involving the body, soul and spirit (Tetteh and Faulkner, 2016). Substituting orthodox cancer treatment for spirituality as the only means of treatment will

be detrimental to the health and well-being of patients. Hence, spirituality should not be a substitute for conventional orthodox treatment for cancer. The need for psychosocial interventions and support is particularly critical in Africa for common misconceptions about the origin of cancer resulting from spiritual or supernatural causes and curses (Opoku, Benwell and Yarney, 2012). The psychological well-being of individuals having a disease or somatic symptoms that are chronic is significantly impacted on. Hence, the attribution of diseases is a vital psychological issue when addressing physical symptoms.

Attribution of blame could have negative consequences on the thoughts, feelings, behaviour and the manner of adherence to the treatment of a patient with cancer. This can make patients predisposed to other life-threatening diseases and even hinder the progression of treatment and proper management of the disease. According to Gómez-de-Regil (2014), research has increasingly drawn attention to people's beliefs about health or illness, which can clearly influence their behaviour. Exploring patients' perceptions of their disease is an important aspect of clinical practice as the perception of patients' illness can affect their likelihood of seeking treatment and sticking to treatment. Therefore, attribution of blame influences how individuals manage somatic symptoms and diseases (Zhang, Schwarz, Kleinstäuber, Fritzsche, Hannig, *et al.*, 2018). Despite previous researches on blame attribution, it is still a common problem among newly diagnosed cancer patients. This study therefore investigated the effects of LT and CR in the management of blame attribution among newly diagnosed cancer patients.

Logotherapy (LT) and Cognitive Reframing (CR) have been effective in managing psychosocial issues involving cancer patients. Logotherapy is one of the most famous existential therapies developed by the neurologist, psychiatrist and survivor of the Austrian Holocaust Frankl in the 1940s. The word "logo" is a Greek word which means “meaning”. The basis of this therapy is that the underlying need of human existence is to find meaning in life. Logotherapy is a decisive extension of the Freudian theory of psychopathology, with far-reaching therapeutic implications. Focusing on these implications, Frankl is of the opinion that in addition to somatic or psychic diseases, a problem of conscience in the form of ethical conflict or existential crisis is often the cause of disorder. These neuroses are called "noogenic" and have a place next to

somatogenic and psychogenic neuroses (Hoffman, Brintnall, Brown, Ige, Jones, *et al.,* 2013).

Logotherapy represents the psychotherapy attempt from the "spiritual" aspect, it constitutes the specific treatment of noogenic neuroses and is also a valuable aid for somatogenic and psychogenic diseases. It emphasizes the power of self-determination and the responsibility of the individual in his own life. Frankl (2006) suggests that the search for meaning is essential to a fulfilling life and that it can be better acquired through the encounter or experience of another; good work or good deeds or through the attitude one chooses to adopt in times of suffering. LT has proven to be an effective intervention that helps patients cope with health problems, find meaning in life, and become more engaged in leading fulfilling lives in all health situations.

Patients with blame attribution have been observed to experience difficulty in finding explanation to their condition which makes them consider people, situation and environment as the cause of their cancer. An exposure to LT could redirect their thinking by finding better purpose and meaning to life and events. LT treatment is capable of reducing blame attribution in individuals by gaining more meaning to life which gives peace to their soul and as well creates happiness with life instead of feeling lost or dissatisfied. Empirical evidence has confirmed the effectiveness of LT in helping people live a beter life which negates blame attribution perspective, helping patients respond to suffering in a more meaningful way, realizing their potential and coping with their struggles in a more effective manner (Rahgozar and Giménez-Llort, 2020).

Cognitive reframing (CR) is another therapeutic technique used by the researcher because of its effectiveness in the field of psychology to solve problems. Cognitive reframing, an essential component of cognitive-behavioural therapy, refers to the general change of mentality and almost all changes of consciousness in a person's mental perspective. (Beck, 1997). CR is about identifying and then questioning irrational or maladaptive thoughts, visualizing and living circumstances, ideologies, emotions and concepts in a bid to identify more possible alternatives. When individuals develop negative thoughts, it could lead to irrational beliefs such as blame attribution. Hence, CR could be used to bring about a change in their mindsets so as to come up with more positive thoughts which could decrease or eliminate irrational beliefs. The ultimate goal

of CR is to change negative thoughts into positive ones. Cognitive reframing is a therapeutic approach whose efficacy has been tested empirically as it uses different methods to help the client understand the irrationality of their thought pattern. Therefore, the client would learn to devise irrational alternatives to such irrational thought patterns, acting more appropriately in future problems (Nathan and Gorman, 2002).

Cognitive reframing is mostly related to cognitive behavioural therapies that seek to reduce psychological distress by altering what individuals think about as well as the way individuals interpret and think about experiences or situations (Beck *et al.,* 1979). The purpose of using cognitive reframing as an intervention is to expand behaviour by helping the client to alter the social or verbal context so that the degree to which these cognitions regulate behaviour is reduced. Furthermore, CR helps the clients view their cognitions not as undisputable facts but rather as hypotheses to be tested against logic and experiential evidence, hence, creating a distance between the thinker and the contents of the thoughts and encouraging the client to get in contact with his or her experiences in the present moment. It can be used to intervene early in the emotion generating process by altering how individuals interpret and evaluate the emotionally relevant circumstances (Wolgast, Lundh and Viborg, 2013).

Blame attribution in this context can be assumed to be the result of negative thinking. The idea that cancer is associated with witchcraft or evil arrows can be considered as irrational in the perspective of Beck (2005). Therefore, an exposure to CR will reduce irrational thoughts associated with blaming people or things as the cause of cancer through positive confrontation and self-talk. The therapist in this situation will engage the clients by helping them understand how to counter negative thoughts with positive ones, thereby developing a better feeling about life and their present situation. Through CR, cancer patients can start seeing their condition as a phase of life that will change.

Logotherapy, which is a meaning-centered approach to psychotherapy, is compatible with cognitive reframing. The basic tenets of LT have the potential to increase both the efficacy and effectiveness of the therapeutic process. The main techniques of logotherapy provide specific and practical examples of how they can be used along with a cognitive reframing intervention (Ameli and Dattilio, 2013**).** The two

therapies emphasize that modifying internal maladaptive attitudes leads to behavioural change. Their main goal is to resolve present issues through a caring and warm therapeutic alliance. Both approaches are active, participative, and collaborative, using a process of guided discovery without the therapist imposing personal concepts of reason or meaning. The two approaches are sound, brief, solution-focused and take into account empirical research (Ameli, 2016; Ameli and Dattilio, 2013).

Many variables can affect the results of this study and need to be controlled. These include gender, age, management style, level of education, socio-economic status, cultural orientation and religious beliefs. However, this study examined social support (SS) and health self-efficacy (HSE). Social support is the perception and reality in which a person is cared for, can be helped by others, and is part of a social support network. These support resources can be emotional, tangible, informative or companionship. Social support includes functions that other important people (families, friends, and health professionals) perform with people who are under stress. Social support can be measured by the feeling of being able to receive help, in form of the real support received, or the degree of integration of a person into a social network. Different forms of social support originate from various sources, such as family, friends, pets, organizations, colleagues, and more. Social support is described as a verbal and non-verbal communication between the recipient and the provider, which reduces the uncertainty of the situation, of oneself, of the other party or of the relationship, and reinforces the awareness of the personal control (Albrecht and Adelman, 2006). It is connected with many gains for physical and mental stability (Wills and Filer, 2001).

Social support provides people with a mechanism to deal with the stressful events of their lives. Social support networks can mitigate the negative effects of physical and mental stress on health (Seeman, 1996). Social support has been shown to reduce psychological distress in times of crisis and has many health benefits, including resistance to life-threatening diseases. Social support can prevent disease, speed recovery and reduce the risk of death from serious illness (Kim, Sherman and Taylor, 2008).

In the context of blame attribution among newly diagnosed cancer patients, social support has proven to enhance psychological adjustment and reduced negative outcomes. It has also shown to effectively reduce negative psychosocial outcomes associated with

cancer (Koopman, Hermanson, Diamond, Angell and Spiegel, 1998). Patients who enjoy more support are likely to adjust better to unpleasant conditions than those with low social support especially in terms of enjoying physical, informative and tangible aid from those close to them and having them available to render such assistance whenever they are needed.

Another factor that can mitigate the attribution of blame among cancer patients is health self-efficacy. Self-efficacy is conceptualized as the belief a person has in his ability of and to perform certain behaviours. (Bandura, 1977). Self-efficacy affects the challenges people face and the extent to which they are defined. Self-efficacy affects people's efforts to change risky behaviours and the persistence of sustained efforts despite the obstacles and frustrations that can hinder motivation. Self-efficacy alters people's feelings, thoughts, and behaviours (Bandura, 1997). It is primarily connected with healthy behaviour, whereas, it can also have an effect on healthy behaviour secondarily through its influence on the target. Health self-efficacy confirms a collection of health-related behaviours, like exercise, diet, condom use, dental hygiene, seat belt use, breast examination and the diagnosis of cancer, all depending on the degree of self-efficacy of a person (Conner and Norman, 1996). A healthy belief in self-efficacy is a cognition that determines whether it will initiate a change in behaviour, how much effort and how long will it take to overcome obstacles and failures (Schwarzer, 2001).

Bandura (1991) argues that self-efficacy can also promote health. He went on to explain that lifestyle habits would improve or impair health. This allows individuals to exert behavioural effects on vitality and healthy change. It involves knowing if people are thinking about bringing about a change in their health habits, the willingness and determination they need to bring about a change, and how they decide to maintain their new habits. The stronger a person's sense of self-efficacy, the more successful they will be, and the less they will engage in harmful health behaviours and the integration of healthy habits into their normal lifestyle. Persons with a relatively strong degree of self-efficacy are more probable to maintain healthy behaviour, probably because they understand barriers as challenges to be conquered (Maibach and Murphy, 1995).

Self-efficacy in health plays an important role in behaviours, health outcomes, health care and promotes the uptake, initiation, and maintenance of health promotion

behaviours (Schwarzer and Luszczynska, 2005). Patients who are better equipped with adequate confidence and capabilities to successfully engage in and execute necessary behaviours needed to cope with the diagnosis of cancer as well as take required steps towards adhering to treatment plans and medical advice will be in better positions to manage blame attribution better than those who are not capable and willing to engage in health promoting behaviours.

For many years, previous research on blame attribution and cancer focused largely on psychological and social factors influencing blame attribution, factors affecting its prevalence in cancer patients and on its effects attributed to cancer patients, while its management and reduction had received little attention. In addition, most of the findings on the attribution of blame of diseases is based on researches conducted on populations in developed countries. There is a need to study culture-specific attribution characteristics, as there are cultural differences in health behaviour and attribution of disease. In view of this context therefore, this study investigated the effects of Logotherapy and Cognitive reframing in the management of blame attribution among newly diagnosed cancer patients in southwestern Nigeria, using social support and health self-efficacy as moderating variables.

1.2 Statement of the Problem

Blame attribution has been identified as a factor that hinders newly diagnosed cancer patients from seeking and adhering to orthodox treatment in order to properly manage the disease. This affects the patients, the care givers and health care professionals. The researcher's experience in the field as a volunteer psycho-oncologist delivering psychosocial support to cancer patients is a motivating factor for embarking on this study. While interacting with cancer patients especially those at the end of life stage, the researcher gathered information that most cancer patients had initially attributed the causes of their illness to a lot of factors that made them run away from conventional orthodox cancer treatment. Experience from the field revealed that most patients had gone through a lot of emotional problems associated with blame attribution. Blame attribution in cancer could lead to psychological distress, withdrawal, failure to adhere to orthodox treatment among the patients which could also lead to poor management of the

disease. Blame attribution is a risk factor for reporting late for medical treatment especially when prognosis has become poor. Most cancer patients are in extreme difficulty coping with the diagnosis of the disease and making a concrete decision to continue with orthodox mode of treatment. Patients with extreme levels of blame attribution are preoccupied with the belief that their current condition is as a result of 'spiritual attack' and so they may decide to search for an alternative cure to the illness.

The negative effects of blame attribution on cancer patients is that management of the disease as well as recovery outcomes become poor as they later come back to the hospital during the last stage of the disease when all other efforts aimed at getting an alternative cure had proved abortive. A cancer patient, who is engrossed in brooding over the possible cause of the disease rather than concentrating on treatment and the possibility of managing the illness, may be at a high risk of anger and guilt and may not be able to overcome depression. When blame attribution is reduced in cancer patients, they are more able to face orthodox treatment and adhere to the rules of managing the disease. When blame attribution is properly managed, the patients are more able to cope with and manage the disease properly. On the other hand, when the problem persists, mortality rate in cancer patients increases as the patients' condition deteriorate due to the metastatic nature of cancer.

With rapidly rising cancer incidence in low and middle income countries including Nigeria, efforts to improve early cancer diagnosis and treatment through system-level interventions and individual behavioural interventions are critical to reduce cancer mortality. Unfortunately, there are major barriers to medical help-seeking for symptoms, and decisions to access healthcare for diagnosis and treatment in low and middle income countries. There is the need to raise cancer awareness, modifying negative beliefs and addressing cultural barriers that prevents diagnosed Nigerians from assessing orthodox medical care and treatment. This study therefore utilized logotherapy and cognitive reframing in the management of blame attribution among newly diagnosed cancer patients in southwestern Nigeria to enable them adhere properly to orthodox treatment using social support and health self-efficacy as moderating variables.

1.3 Objectives of the Study

The main objective of this study was to investigate the effects of LT and CR on blame attribution among newly diagnosed cancer patients in southwestern Nigeria.

Specifically, the study:

- examined the main effect of treatments on blame attribution among newly diagnosed cancer patients.
- determined the main effect of health self-efficacy on blame attribution among newly diagnosed cancer patients.
- investigated the main effect of social support on blame attribution among newly diagnosed cancer patients.
- found out the interaction effect of treatments and health self-efficacy on blame attribution among newly diagnosed cancer patients.
- evaluated the interaction effect of treatments and social support on blame attribution among newly diagnosed cancer patients.
- assessed the interaction effect of health self-efficacy and social support on blame attribution among newly diagnosed cancer patients.
- ascertained the interaction effect of treatments, health self-efficacy and social support on blame attribution among newly diagnosed cancer patients.

1.4 Hypotheses

In this study, the following null hypotheses were tested at 0.05 levels of significance:

H_{01}: There is no significant main effect of treatments on blame attribution among newly diagnosed cancer patients in southwestern Nigeria;

H_{02}: There is no significant main effect of health self-efficacy on blame attribution among newly diagnosed cancer patients in southwestern Nigeria;

H_{03}: There is no significant main effect of social support on blame attribution among newly diagnosed cancer patients in southwestern Nigeria;

H_{04}: There is no significant interaction effect of treatments and health self-efficacy on blame attribution among newly diagnosed cancer patients in southwestern Nigeria;

H_{05}: There is no significant interaction effect of treatments and social support on blame attribution among newly diagnosed cancer patients in southwestern Nigeria;

H_{06}: There is no significant interaction effect of health self-efficacy and social support on blame attribution among newly diagnosed cancer patients in southwestern Nigeria;

H_{07}: There is no significant three way interaction effect of treatments, health self-efficacy and social support on blame attribution among newly diagnosed cancer patients in southwestern Nigeria.

1.5 Significance of the Study

The outcome of this study will be of immense benefit to the study participants, other cancer patients, their caregivers, medical practitioners, clinical and counselling psychologists, mental health professionals, academia, professional bodies, policy makers and future researchers.

The findings of this study should improve the participants and their caregivers' knowledge about cancer, the risk factors, signs and symptoms. It is anticipated that this would reform the perception of the patients and their caregivers and it will better equip them to form a strong decision to take up and adhere to orthodox treatment geared towards the management of the disease rather than looking beyond medical perspective for a cure or spending resources and efforts on other means in search of a cure.

For clinical and counselling psychologists, the findings of this study would provide information for identifying clients experiencing blame attribution and other adjustment problems related to cancer diagnosis. It will also equip them with the knowledge of reducing the emotional and behavioural problems associated with blame attribution using psychotherapeutic techniques thereby leading to behavioural change.

The findings of this study will be of immense benefit to medical doctors, nurses, oncologists; social workers, psychiatrists, psycho-oncologists and psychotherapists. The medical practitioners stand to benefit from the outcomes of this study because it is a vital area that relates directly to adequate health management. Programmes could be designed and organised to spread messages that could encourage screening and prevent more occurrence of late cancer stage presentation among Nigerians and also to encourage

cancer patients to undergo appropriate orthodox treatment as this could serve as a public health strategy to reduce mortality associated with cancer prevalence in the country.

Also, this study will be relevant to the academia and professional bodies such as Counselling Association of Nigeria (CASSON), The Psycho-Oncology Society of Nigeria (POSON), International Psycho-Oncology Society (IPOS) and other research institutions especially relating to oncology. In the aspect of scholarship, it will make a significant contribution to existing knowledge in the area of cancer and blame attribution both locally and internationally.

The study is expected to constitute an invaluable reference document in the hands of the Nigerian government and its relevant agencies towards policy formulation and programme implementation on cancer. There is the need for relevant agencies to look into and work on the need to provide free screening for and treatment of cancer patients. This study is expected to create an insight into this important need. In the same vein, research institutions, NGOs and similar interest groups with a passion for managing cancer patients will be interested in the observations of the study for their appropriation.

The results of this study will be useful in making recommendations for managing the psychosocial needs of cancer patients by researchers and policy makers. The findings of the study could serve as reference material for future researchers. Also, recommendations from the study and suggestions could be useful for future studies in the area.

There is the need for collaboration between oncologists and psycho-oncologists in order to achieve a wholistic approach towards managing and proferring solutions to the psychosocial needs of cancer patients. This will make it possible for all individuals faced with the care of cancer patients to work towards ensuring that a multi-dimensional approach is used to cater for the needs of cancer patients along the cancer care continuum i.e awareness, screening, diagnosis, proper treatment and end of life (where applicable). This study is expected to provide a platform for such partnership to exist as it would lead to the need to embrace the psychological and social aspects of care for cancer patients holistically.

1.6 Scope of the Study

This study investigated the effects of logotherapy and cognitive reframing in the management of blame attribution among newly diagnosed cancer patients in southwestern Nigeria. The moderating effects of health self-efficacy and social support on the participants' blame attribution tendencies were also examined. The participants were newly diagnosed cancer patients. The study was carried out in southwestern Nigeria and it utilized a pretest-posttest, control group, quasi-experimental research design.

1.7 Operational Definition of Terms

In order to ease the understanding of terms used in this study, the following terms were operationally defined as used within the context of the study.

Blame Attribution: A situation whereby newly diagnosed cancer patients in southwestern Nigeria attribute the cancer disease and the causes of the disease to themselves, the activities the individuals had previously engaged in, the environment or to significant others.

Logotherapy (LT): A therapy used to assist newly diagnosed cancer patients in southwestern Nigeria to find meaning in life and illness and to learn to cope with difficult situations instead of attributing the cause of their illness to someone or something.

Cognitive Reframing (CR): A therapeutic technique used in this study to help identify and thereby dispute maladaptive or irrational thoughts and resolve emotional and behavioural problems associated with blame attribution of the newly diagnosed cancer patients in southwestern Nigeria.

Social Support: The extent to which the newly diagnosed cancer patients in southwestern Nigeria believe they are cared for by significant others (health care professionals, friends and family) available around them that can control blame attribution.

Health Self-efficacy: The newly diagnosed cancer patient's beliefs in their confidence and capabilities to successfully engage in and execute necessary behaviours required to manage blame attribution.

Newly Diagnosed Cancer Patients: Patients diagnosed of cancer in southwestern Nigeria within six months of the commencement of the study.

CHAPTER TWO

LITERATURE REVIEW

Literature was reviewed extensively on the concepts of the dependent and independent variables: Blame Attribution (BA), Logotherapy (LT) and Cognitive Reframing (CR). This includes the theoretical and empirical background of the variables.

2.1 Conceptual Review of Literature

2.1.1 Concept of Blame Attribution (BA)

Attribution alludes to individuals' trademark method for clarifying reasons for occurences (Abramson, Seligman and Teasdale, 1978; Harvey and Martinko, 2009). Attributions are decisions in which an encounter, conduct or occasion is associated with its source, cause, manner, or agent responsible for it. For Peterson, Seligman, Jurko, Martin, and Friedman (1998), causal connections are credited to the way individuals ascribe causation to positive and negative things. Abramson *et al*., 1978 explain how individuals clarify the victories and disappointments throughout everyday life and whether they ascribe these to themselves or others, present moment or long-term factors, and factors that influence all circumstances.

Attribution is a behaviour that the individual engages in each day, and frequently doesn't comprehend the fundamental procedures and preferences that lead to such behaviour. An individual may make various attributions to their conduct and the conduct of the individuals around him daily. When test scores are bad, the individual may blame the instructor for not completely clarifying the reading material. Hence, totally overlooking the way that he or she did not completely practise what was taught in the first place. At a point when a cohort gets a high score on a similar test, this accomplishment might be ascribed to luck, disregarding the way that the individual has great examination skills. People ascribe interior attribution to specific things and outside attribution to other people. Individual everyday attribution significantly affects a person's

sentiments just as his relationship and identification with others (Goldinger, Kleinder, Azuma and Beike, 2003; Kendra, 2016).

Attribution of blame is the way towards inducing an occasion or a reason for an activity. It is a structure that guarantees that when an individual experiences an abrupt danger or natural change, the individual will start a causal hunt to comprehend the reason for the risk or change (Harvey and Weary, 1981). This attribution search is believed to comprehend, foresee, and control dangers. Along these lines, it might be especially helpful from the beginning while trying to adjust to a situation.

Blame attribution (BA) is a significant yet under-examined factor for adjustment to malignant growth (Servaes, Verhagen and Bleijenberg, 2002). Studies on malignancy patients (Costanzo, Lutgendorf, Bradley, Rose and Anderson, 2005) and clinical perceptions (Block, Nolan, Sattler, Barr, Giacoletti, *et al.,* 2006) have proven that numerous individuals ascribe their disease to an assortment of individual variables, for example, dietary patterns, negative feelings or stress. Investigations of patients for example with disease like lung cancer have indicated that BA is typically hurtful (Faller, Schilling and Lang, 1995) and may aggravate depressive and anxious feelings including reduced satisfaction in life (Block *et al*., 2006).

Notwithstanding the realized hazard factors for specific malignancies, people affected by the disease may build up a hypothesis of their malignancy etiology depending on the information at their disposal. In this procedure, people make attributions of sound judgment hypothesis or occasions, attempting to comprehend their situation, which is called attribution hypothesis in the study of human behaviour (Kelley and Michela, 1980). A developing assemblage of proof recommends that attribution of sicknesses and other occurences that threaten life is related with adjustment problems, unaccepted behaviours related to health, and absence of trust in the capacity of individuals to control the problem outcome (Timko and Janoff-Bullman, 1985). This may clarify why attribution can anticipate the occurrence of certain sicknesses, and when the infection is progressively serious, the patient is well on the way to search for the reason (Affleck, Tennen, Croog and Levin, 1987).

Individuals' convictions about the idea of the sickness and its signs influence how they react to it (Bates, Rankin-Hill and Sanchez-Ayedez, 1997) and prescription

adherence (Horne, 2006). Asuzu, Akin-Odanye and Philip (2015) attest that the manner in which individuals manage issues regularly relies upon their experience and social direction, which are fundamentally founded on their beliefs. Along these lines, convictions about the beginning of the ailment and its cure are significant contemplations since they may impact the patient's view of the illness, mentalities toward the malady, and sentiments about the infection and living conditions. Eisenbruch, Yeo, Meiser, Goldstein, Tucker, *et al.* (2004) stated that various individuals' mentalities toward dangerous illnesses rely upon their social foundation, while Helman (1994) accepts that each culture has its very own convictions, arrangement of thoughts, considerations about wellbeing and infection.

The conviction that malignant growth has a mystical causative factor (Opoku, Benwell and Yarney, 2012) may prompt sentiments of vulnerability and depression, turning into an undetectable power that can prompt sadness. Malignant growth diagnosis brings a wide scope of convictions and pictures. These convictions impact choices about whether to take preventive measures, when to look for therapeutic guidance, and which treatment to take (Dein, 2004). Furthermore, for many patients, healthcare practitioners are a last resort in addressing health concerns, this is another contributor to late-stage diagnosis and poor cancer outcomes (Pruitt, Mumuni, Raikhel, *et al.*, 2015). The stage of cancer at presentation is an important contributor to the mortality and outcome of cancer treatment. Cancer care in Nigeria is characterized by late stage presentation after first symptom and delayed diagnosis (Oladeji, Atalabi and Jimoh *et al*., 2017).

Blame attribution influences health beliefs and ensuing practices related to health. Attribution is partially shaped by culture. Thus, social wellbeing attribution influences convictions about sickness, treatment, health practices, and therapeutic adherence (Vaughn, Jacquez and Baker, 2009). Social and spiritual components assume a significant impact in malignancy understanding, marking and treatment in the southwest (Olasoji, Ahmad, Ligali and Yahaya, 2011). These likewise assume a significant turn in how various patients get to perceive malignant growth, how they clarify the disease, and their frames of mind towards the disease (Powe, 1995).

Individuals of various social foundations frequently have various attributions to ailment, wellbeing, infection, side effects and treatment. Attribution assumes a significant

impact in the development of convictions about wellbeing and sickness (Murguia, Peterson and Zea, 2003). These wellbeing convictions may frame the thinking patterns that impact individuals to make attributions. For instance, African Americans may credit infection to destiny or God's will and put stock in the recuperating intensity of petition (Gregg and Curry, 1994). Somewhat English Americans may hold increasingly conventional western wellbeing convictions, for example, moral obligation regarding wellbeing and infection (Landrine and Klonoff, 1994) and progressively observational clarifications for the illness (Furnham, Akande and Baguma, 1999). Numerous American whites accept that illnesses can be treated regardless of family, network or divine beings (Landrine and Klonoff, 1992).

African patients are bound to ascribe the sickness to mental or social reasons than to physical or logical reasons (Madge, 1998). Furthermore, African patients are bound to expect experts in health practice to give explanations and reasons for being afflicted with disease such as crediting the ailment to extraordinary causes, condemnations or other worldly reasons (Mulatu, 2000). Chipfakacha (1994) declares that most dark Africans ascribe illness to superstition and accept that the infection is brought about by devil and wicked beings. The reason for the illness is identified with the contention, pressure and concordance or disharmony among wicked beings. Thus, so as to viably treat these maladies, therapeutic remedies must be taken through natural prescription and spiritual clarifications and methods.

Cultural beliefs about the cause of breast diseases and associations of the female breasts with nurturance, motherhood and femininity influence diagnosis and management of breast cancer in Sub-Saharan Africa. Social and cultural factors influence women's experiences of breast cancer, social constructions of the disease and allocations of resources to manage the disease (Mdondolo, De-Villiers and Ehlers, 2004). In traditional African society, good health is understood as a desirable relationship between the living and the dead and harmony between individuals and their environments. Thus, disease is conceptualized as involving malfunctioning of the body organs and lack of harmony with supernatural or ancestral forces (Omonzejele, 2008). This understanding influences how diseases are diagnosed and treated, steps taken to manage the disease and ultimately how the disease is experienced. In Sub-Saharan Africa, breast cancer is associated with

supernatural forces, hence the preference to seek alternative treatments such as healing or prayer camps for breast diseases. Most women in Sub-Saharan Africa use traditional medicine and/or alternative treatments first and only report to hospitals when their breast cancer symptoms have worsened (Opoku, Benwell, Yarney, 2012). Associating breast cancer with supernatural and ancestral causes produces guilt and lack of control over the disease for most Sub-Saharan African women (Schlebusch and VanOers, 1999). Women feel guilty that they have wronged their ancestors, and therefore believe they are being punished with breast cancer because of the belief that the living cannot contend with the dead. Ancestors are believed to have powers to protect, heal and kill thus, a good relationship with the ancestors is linked to good health (Omonzejele, 2008).

Culture affects both the risk factors for cancer as well as the meaning of the disease by establishing norms of behaviour and providing guidance for its members to respond emotionally, cognitively, and socially to this disease. Thus cultural beliefs and practices affect cancer care along the entire disease continuum from prevention and early detection, treatment choices and adherence rates, management of side effects such as pain and its control, appropriate psychosocial support, rehabilitation efforts, survivorship issues, hospice use, and effective end of life care (Kagawa-Singer, 2000). Culture determines the different ways that patients understand cancer, the ways they explain it, and their attitudes towards it. These factors affect the patient's emotional response to the disease and health behaviour in terms of prevention and treatment (Dein, 2004). Appraisals over the cause, course and cure of cancer may have distinct and important implications, which can inform therapies for cancer survivors during and after treatment. Also, religious appraisals may be important to address, even in patients who do not strongly identify as religious. While causal attributions may be useful in promoting positive health behaviour changes in survivor, they may also predict negative affect. (Carney and Park, 2018). Without definitive information, patients often shape their own beliefs on the cause of their illness, developing causal attributions. (Staal, Vlooswijk, Mols, *et al.*, 2021)

It is common practice in most African communities to combine traditional and western or modern medicine for treatments of ailments. Due to the fact that these belief systems and practices impact breast cancer management in Sub-Saharan Africa,

Omonzejele (2008) suggest that they must be addressed in breast cancer awareness and education programmes. Tesfamariam, Gebremichael, Mufunda (2013) was of the opinion that seeking alternative treatment for breast cancer indicates a preference for traditional medicine instead of western or modern medicine in Sub-Saharan Africa. In contrast to western medicine, traditional medicine is considered affordable, readily accessible, trustworthy and holistic because it involves the body, soul and spirit. Traditional healers are trusted because women believe they look for both scientific and metaphysical causes and cures for diseases including cancers (Asobayire and Barley, 2014). These socio-cultural beliefs and practices have spurred denial of risk of breast cancer, fear of mastectomy and chemotherapy, failure to adhere to treatment, among other attitudes that inhibit early diagnosis and management of the disease in Sub-Saharan Africa (Anyanwu, Egwuonwu, Ihekwoaba, 2011). Religious beliefs are considered a source of strength and a way to cope with serious diseases. Religious misconceptions, social pressures, and mistaken beliefs contribute to lack of breast cancer screening efforts and delayed help-seeking attitudes among Pakistani women. A lot of people show a general lack of awareness about the nature of the disease and its treatment and this leads to alternate treatments which are usually ineffective (Saeed, Asim and Sohail, 2021).

In Nigeria, routine cancer screening programmes are largely unavailable (Ishola and Omole, 2016) and there are various myths that surround cancer especially as it relates to prevention and treatment. The multiple system that includes standard, alternative and traditional health care delivery systems in Nigeria, all operating alongside one another may contribute to delayed treatments (Asuzu *et al.*, 2019; 2017). Spiritual healing seems to be an alternative that many Nigerians use to address some of their health needs. Also, people realize that there are limited options regarding access to cancer care, and many feel more inclined to seek pastoral care when they receive negative diagnosis (Ezeome and Anarado, 2007). Early diagnosis is relevant in all settings and improves survival for many cancers. However, it is possible that the parents of children who abandon treatment would patronise alternate sources of healthcare for solution (Brown and Adeleye, 2017).

Some cancer cases are missed as a result of deaths before presentation to health-care facilities when patients choose to seek alternative or traditional forms of treatment. Such an attitude may have resulted from ignorance, limited or lack of access to

specialized medical care. This leads to loss of data as available data might be an underestimation of true cancer burden (Yusuf, Atanda, Umar, Imam, Mohammed, *et al.*, 2017). Poor knowledge regarding cervical cancer in at-risk populations directly affects health-seeking behaviour and is associated with high mortality among women with cervical cancer (Imran, Morhason-Bello, Kareem, and Adewole, 2020).

Getting to commence cancer treatment early can improve outcomes in prognosis. Psychosocial factors influencing patients' medical help-seeking decisions is needed to understand the psychosocial influences on medical help-seeking for cancer symptoms, attendance for diagnosis and starting cancer treatment. The use of traditional, complementary and alternative medicine and cultural influences appear to be important barriers to medical help-seeking behaviour in low and middle income countries and is influenced by causal beliefs, cultural norms and a preference to avoid biomedical treatment. Women face particular barriers, such as needing family permission for help-seeking, and higher stigma for cancer treatment. Additional psychosocial barriers include shame and stigma associated with cancer such as fear of social rejection related to divorce, limited knowledge of cancer and associated symptoms, financial and access barriers associated with travel and appointments (McCutchan, Weiss, Quinn- Scoggins, *et al.*, 2021).

Myths and misconceptions such as the 'evil arrow' myths (attack of the enemy in a supernatural version as a result of wizardry) have had significant impact on the presentation and management of cancers worldwide, particularly in African countries where cancer patients are excluded from society and have poor emotional support. Hence, patients accept their condition as either a victim of the evil arrow or a mere disease with an unknown cause which contributes to reasons why patients present late to hospital (Birhanu, Abdissa, Belachew, *et al.*, 2012).

The manners in which cancer survivors understand their disease can have important implications for how they respond to it. Beliefs following a cancer diagnosis have been shown to relate to adjustment following the diagnosis (Jenkins and Pargament, 1988). The beliefs are those regarding the cause of the cancer (often termed attributions) and control over the course and cure of the cancer. Secular appraisals of the cause and cure of illness often concern the self, while religious appraisals typically concern God

(Cousson-Gélie, Irachabal, Bruchon-Schweitzer, Dilhuydy and Lakdja, 2005). These may have different associations with psychological adjustment following cancer, depending on whether they relate to the cause or cure of cancer. Both religious and secular appraisals of the cause of cancer have been related to negative outcomes. Self-blame has been associated with adjustment to traumatic life changes including cancer (Bulman and Wortman, 1977) and while findings are not entirely consistent, it appears to be a common predictor of poor adjustment (Else-Quest, LoConte, Schiller, Hyde, 2009; Kulik and Kronfeld, 2005). In a sample of prostate cancer survivors, attributions of cancer's cause were related to poorer quality of life (Gall, 2003).

Helman (2001) proposes that individuals attribute the reason for the illness to the person's very own faults (abnormal behaviours or states of emotion that are demoralising), factors in the environment (contamination and microscopic organisms), and elements identified with others in the social world (pressure, unavailability of medical resources and the activities of others), predetermination and indigenous convictions like black magic or voodoo. In this way, understanding the patient's convictions about the disease is identified with the treatment of the disease and can likewise help anticipate their capacity to react and recuperate (Diefenbach and Leventhal, 1996) treatment adherence and conduct (Horne, 2006).

The nature of an illness and its prognosis will have direct impact on the physical and psychological challenges presented to the patient. With frequently little time to deal with diagnosis before having to consider potentially distressing treatment (Galloway *et al*., 1999), rapidly unfolding events may lead to feelings of powerlessness with threats to physical and emotional identity, work, role and financial security. With chronic or terminal illness, people often need to review self-concepts, roles, relationships and grieve for the loss of their anticipated future. All of these variables will impact significantly on how any physical problem is experienced and these will need to be assessed. (Bussuttil, *et al*., 2015). Personal factors that contribute to a person's capacity to live with or adjust to their condition include:

1. Health Beliefs:

Adopting healthy behaviours and desisting from unhealthy ones involves making the decision to change, implement change and maintain change. Likelihood of change is influenced by:

i. Belief that one is at personal risk

ii. Outcome expectancy that behavioural change will decrease risk

iii. The belief that one can change and maintain change (Bandura, 1994). The nature of these health beliefs is very important in determining a person's psychological response to a particular physical condition and to their willingness to adopt the treatment regimen associated with it.

2. Coping Style:

The relationship between physical health problems and psychological distress is influenced by a person's coping style (Miller *et al*., 1998). Coping is a dynamic process influenced by individual and environmental factors. Acute illness, where disruption to one's life may be temporary, calls for different coping responses to a chronic illness where the goal is to maintain quality of life, manage symptoms and reduce disability. (Bussutil, *et al*., 2015).

3. Adjustment:

Moos and Holahan (2007) describe the following adoptive tasks in illness and disability.

i. Managing symptoms and treatment

ii. Forming relationships with health care professionals

iii. Managing emotions

iv. Maintaining self-image

v. Relating to family and friends

vi. Dealing with an uncertain future.

While most people successfully adjust, the process of adjustment is fluid and changing, accompanying changes in either the physical condition or a person's life circumstances. Self-blame can feature if lifestyle choices contributed to the condition. An inability to undertake family or work roles expected by self or society may result in shame and guilt as this can make adjustment more difficult. Some people may struggle to

adapt to changes in their appearance. Positive developments also occur as over a quarter of patients with diabetes reported positive outcomes in at least one area of their lives (Nicolucci, *et al*., 2013).

4. Lifespan Issues:

The point we are at in our lives can affect our psychological response to illness or disability. Some types of disability may be easier to adjust to later in life than earlier in life, as these can be a cultural expectation of having to manage more complex physical health concerns in later life which can make disability less unexpected. A person with persistant pain may have adapted well but may need to make new adaptations when they have children and find that they cannot undertake expected parental roles. Thus, adjustment, particularly to a long-term condition, remains an ongoing process (Bussutil, *et al*., 2015).

5. Existential Issues:

Illness confronts patients with the deepest human concerns; death is inevitable, we are essentially alone, we are looking for meaning and, while we have freedom, with that comes responsibility for the decisions we make, including those relating to the consequences of accepting or rejecting treatment. People may differ widely in their capacity to process and make sense of these existential issues. People who can create a sense of meaning from their difficulties tend to adjust better than those who cannot (Bussutil, *et al*., 2015).

6. Societal Factors:

The type of society one lives in, including cultural beliefs about illness and the types of support available can have a significant impact on how someone copes with their physical illness. Culture, gender and religious factors affect illness experience. Culture and religion may affect how an illness is perceived, with some viewing some forms of illness as a punishment and others viewing it as an opportunity for further spiritual development. This obviously has a major impact on how someone comes to make sense of, and cope with their illness as well as the amoung of support they are likely to get from society, family and friends (Bussutil, *et al*., 2015).

Health beliefs and behaviours affect health problems. The way in which we appraise adverse events like illness affect how effectively we cope with them. An

individual who approaches a diagnosis of cancer with an optimistic fighting spirit rather than hopelessness is more likely to make positive behavioural health choices such as quitting, smoking and following treatment recommendations (Lazarus and Folkman, 1984). In general, the management of different types of cancer in Nigeria, like in other low- to middle income countries, is faced with many challenges. At initial presentation, advanced stage disease is usually seen, which can be attributed to lack of proper knowledge of the disease, socio-cultural and religious beliefs as well as a delay while seeking solutions from alternative care providers (Okobia, Bunker and Okonofua *et al.,* 2006).

2.1.2 Concept of Cancer Disease

The earliest portrayals of cancer and the most reliable recorded cases were found in obsolete Egypt around 3000 BC. It began with valid record of the old-fashioned Egyptian time span, called Edwin Smith Papyrus (some part of the old Egyptian record). It delineates eight cases of breast tumours or ulcers that have been cut short using an instrument called a "fire drill." (Papavramidou, Paparamidis and Demetriou, 2010).

The origin of the word malignant growth is credited to the Greek specialist Hippocrates (460-370 BC), who is considered the "father of prescription." Hippocrates uses the Greek word "carcinos" (which means crab) to depict tumours that are not ulcerated and ulcerated tumours. This was a direct result of the spread of the tumour to the crab-like finger-like projection, which was later changed over into the word malignant growth by the Roman specialist Celsus (28-50 BC). Another Greek expert, Galen (130-200 AD), used the articulation "oncos" (Greek for extending) to portray the tumour. The term is currently used as a significant part of the name of the disease physicians (oncologist) (Kardinal and Yarbro, 1979). Hippocrates has confidence in the hypothesis of "four humors" (dim, yellow, phlegm and blood). He explained that malignant growth is as a result of fluid abnormality and excessive dim bile (Sudhakar, 2009).

Cancer disease is the major resulting reason behind death on the planet. According to Schutte (2017), it is second just to cardiovascular disease. It caused 8.8 million deaths in 2015. Around one-sixth of the general reasons causing death is the

disease. About 70% of deaths related to the disease take place in countries with less resources and income. Around 33% of malignancy deaths are achieved by five noteworthy social and dietary threats, for instance, record of excess weight, poor fibre intake, and non-attendance of physical activity, smoking and drinking. (World Health Organization, 2018). Breast malignant growth is the most broadly common kind of disease around the globe, trailed by colon, rectal and prostate tumours. In 2016, 8 million people had breast malignant growth; 6.3 million had colon and rectal disease and 5.7 million had been said to have prostate malignancy. These are the three most customary sorts of malignancy in numerous countries. Regardless of their rankings around the world, there are exceptions. In most high and focus pay countries, bronchial malignant growth, bronchial disease and lung disease are the primary kinds of malignant growth. Nevertheless, the key kinds of malignant growth deaths in low-compensation countries change. This encompasses colon and rectal malignant growth, liver disease, cervical malignancy, stomach malignancy, breast malignancy and prostate malignancy (Roser and Ritchie, 2018).

Cancer is estimated to be responsible for 9.6 million deaths in the world in 2018, where cancer causes 1 in 6 deaths worldwide (World Health Organization, 2018). The percentage of patient survival after being diagnosed with cancer is usually within 5 years. The proportion of patients recovering from cancer deaths also occurs after 5 years after the diagnosis is established. However, this depends on how the individual interprets the cause of cancer because different patients will experience differences in the detection and treatment of different types of cancers, factors that cause a patient to survive from cancer such as treatment itself, comorbidities, behavioural differences, and biological differences and screening earlier than cancer is experienced (American Cancer Society, 2017).

In 2016, 8.9 million people died of various kinds of malignancy (Institute of Health Metrics and Evaluation, Global Burden of Disease (GBD), 2016). In Africa, Asia, Central America and South America, there are 60% of new cases and 70% of malignant growth-related deaths. As demonstrated by reports, by 2032, 23 million new cases will appear (World Health Organization, 2015). It is assessed that there were 102,100 new malignant growth cases in Nigeria in 2012, of which 71,600 were cancer deaths, speaking to 12% of the 847,000 new malignancy cases in Africa during a comparative period

(Nigeria National Cancer Registry, 2012). About everyone knows or loses a close one to the disease. In any case, only one-fifth of low-and focus compensation countries have the principal data to make policies aimed at reducing malignant growth to be successful (International Agency for Research on Cancer (IARC), 2016).

Malignant disease has ended up being one of the most feared non-transferable afflictions and has transformed into a noteworthy supporter of the overall load of infirmity. The heaviness of malignancy is growing and is one of the principle origins of death around the world (World Health Organization, 2015). There are more than one hundred sorts of cancer disease, and their symptoms differ (Adebamowo and Ajayi, 2000). Around the globe, approximately 10 million people are determined to have malignant growth consistently (Stewart and Kleihues, 2003). Despite the malignant growth being caused by specific things, its relationship with mind hormones and dietary practices involving disease-causing components like smoking and biological substances have also been found. (Azizi, Bahadori and Azizi, 2013).

The occurence of specific sorts of malignancy change worldwide. People of all ages may contact the disease, also most sorts of malignancy are continuously found in people past 50 years of age. Around the globe, most malignancies occur in people past 50 years of age. Around 83-84% of acknowledged disease cases occur in people past 50 years of age, of whom are between 50-69 years old, and 37% are over 70 years old. More than one percent of malignant growths in general occur in adolescents and young people 14 years of age and progressively energetic. Unfortunately, this is equivalent to around 80,000 adolescents for consistently, overwhelmingly in youth malignant growth in the leukemia group (Roser and Ritchie, 2018). Disease when in doubt makes over various years, with no known explanation, and may be a result of a perplexing mix of certain risk factors, for instance, regular, fortifying, lead, and innate components. Nigeria is depicted by specific neighbourhood differentiates in characteristic and inherited risk factors for different malignant growths (Asuzu and Asuzu, 2007).

The malignant growth occurence in Nigeria is twisting up progressively. As demonstrated by the World Health Organization (2015), the country reports 100,000 new malignant growth cases each year, though different observers acknowledge that by 2020, this number may be as high as 500,000 cases for every year. It is surveyed that by 2020,

the recurrence of malignant growth in Nigeria will rise to 90.7/100,000 and 100.9/100,000, independently. Nigeria, a highly populated country, is presently moving towards one of the countries with a high prevalence of malignant growth disease (Anyanwu, 2000).

Cancer is a chronic disease that refers to a collection diseases leading the body cells in different parts of the body to grow uncontrollably, form tumours and spread into surrounding tissues. The cancer cells tend to break off and travel through the circulatory system to other parts of the body as the tumour grows and new tumours are formed. (Siegel, Miller and Jamal, 2019).

Cancer is a syndrome of illnesses that incorporate abnormal cell development that may spread to various bits of the body (World Health Organization and National Cancer Institute, 2014). More than 100 cancers impact individuals. Smoking is liable for about 22% of cancer deaths. The other 10% is a direct result of fat, unhealthy nutrition, lifestyle, non-attendance of physical exercise and alcohol use (World Health Organization and National Cancer Institute, 2014). Various components consolidate certain sicknesses, prologue to ionizing radiation and natural poisons. In countries just developing, about 20% of cancers are as a result of being infected with diseases like hepatitis B, hepatitis C and human papillomavirus (HPV). These components work by changing the characteristics of the cells. Normally, various innate changes are required before cancer comes up. Around 5–10% of cancers are a result of inherited deformations in parental heritage. Cancer can be recognized by explicit signs or screening tests. It is then also investigated by restorative imaging and confirmed by biopsy (Kushi, Doyle and McCullough, 2012).

The most broadly perceived sorts of cancer in men are lung cancer, prostate cancer, colorectal cancer and stomach cancer. Among women, the most generally perceived sorts are breast cancer, colorectal cancer, lung cancer and cervical cancer. In case skin cancer other than melanoma is joined into each and every new cancer consistently, it speaks to about 40% of cases (Cakir, Adamson and Cingi, 2012). Among kids, lymphoblastic leukemia and tumours of the brain are the most generally perceived, yet in Africa, non-Hodgkin's lymphoma is discovered most times. In 2012, around 165,000 children more youthful than 15 were determined to have cancer. The peril of

cancer augments basically with age, and various cancers are progressively essential in high grade countries. This extent is growing as more people live to age and as lifestyles in growing countries change. By 2010, the cash related cost of cancer is evaluated at $1.16 trillion consistently (World Health Organization, 2014).

Cancer cells differ from non-cancerous cells from various perspectives which make them to be fierce and destructive. A huge distinction is that cancer cells are not as explicit as normal cells would be. In addition, cancer cells can ignore signs that commonly encourage cells to stop isolating or start a system called adjusted cell destruction or apoptosis which the body uses to discard needless cells. Cancer cells may have the choice to impact the normal cells, particles and veins incorporating and continuing the tumour. Cancer cells can truly shield the protected structure from killing cancer cells with the help of certain safe system cells that ordinarily keep away from uncontrolled safe responses (Anguiano, Mayer, Piven, and Rosenstein, 2012).

Cancer can in like manner be suggested as an innate sickness, an ailment realized by inherited changes that control cell limits, particularly cell advancement and division. Genetic changes that lead to cancer can be passed through the gene, as a result of botches achieved by cell division or mischief to DNA realized by certain environmental exposures. Cancer-causing natural exposures incorporate substances, for instance, mixtures in tobacco smoke, similarly as radiation from the sun. Cancer has a unique blend of genetic changes. As the cancer continues advancing, various changes will occur. Different cells may have particular inherited changes even inside a comparable tumour. Every now and again, cancer cells have more inherited changes than DNA, for instance some of which may be irrelevant to cancer, and they may be the delayed consequence of cancer, not the explanation (American Society of Human Genetics, 1995).

During the metastasis stage, cancer cells move away from the principal region (basic cancer), spread through the blood or lymphatic system, and structure new tumours (metastatic tumours) in various bits of the body. Metastatic tumours are a comparable sort of cancer as basic tumours. A cancer that spreads from the initial beginning stage to another bit of the body is called metastatic cancer. The system by which cancer cells spread to various bits of the body is called metastasis. Metastatic cancer has a comparable name and type as the first or basic cancer. For example, a breast cancer that spreads and

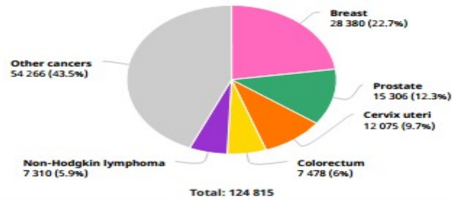
structures a metastatic tumour in the lung is metastatic breast cancer, not lung cancer. Under the amplifying focal point, metastatic cancer cells have a comparative appearance as the primary cancer cells. In addition, metastatic cancer cells and primordial cancer cells routinely have certain typical nuclear characteristics, for instance, the closeness of express chromosomal changes helps drag out the lives of certain metastatic cancer patients. In any case, generally speaking, the fundamental goal of treating metastatic cancer is to control the improvement of cancer or to alleviate the reactions achieved by cancer. Metastatic tumours can really debilitate human limit, and a large number of individuals who become dead as a result of cancer can pass on from metastatic contamination (Anguiano *et al*., 2012). Indications of infection rely on the locale of the tumour. Right when threat starts, it passes on no manifestations. Signs and appearances show up as the mass increases in size or ulcerates. The disclosures that come up rely on the type of the cancer and where it is located.

Local symptoms may occur because of a thump or ulceration. Swelling impacts following lung tumour can affect the bronchi, leading to cold or cough; oesophageal sickness can incite narrowing of the throat, leading to painful swallowing, colorectal disease may make the stomach related tract blocked influencing movement in the bowel. An irregularity in the chest or gonad may make a noticeable mass. General signs happen on account of impacts that are not related to brief or metastatic spread. These may include sudden weight decrease, fever and changes to the skin. Hodgkin sickness, leukemias and compromising advancements of the liver or kidney can cause a continuous fever (Dimitriadis, Angelousi, Weickert, Randeva, Kaltsas and Grossman, 2017).

International Agency for Research on Cancer
World Health Organization

Nigeria
Source: Globocan 2020

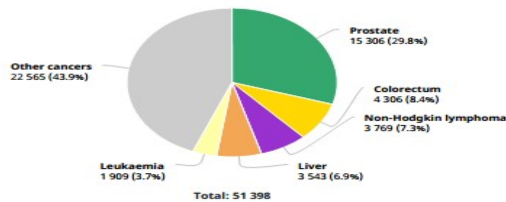
Number of new cases in 2020, both sexes, all ages



Total: 124 815

Geography

Number of new cases in 2020, males, all ages



Total: 51 398

Numbers at a glance

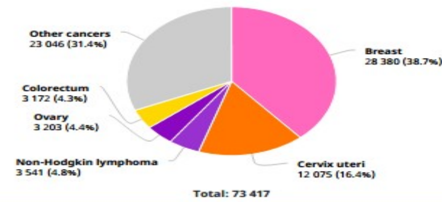
Total population
206 139 590

Number of new cases
124 815

Number of deaths
78 899

Number of prevalent cases (5-year)
233 911

Number of new cases in 2020, females, all ages



Total: 73 417

Data source and methods

Incidence

Country-specific data source: Abuja Cancer Registry, Calabar Cancer Registry, Ekiti Cancer Registry, Ibadan Cancer Registry
Method: Weighted/simple average of the most recent local rates applied to 2020 population

Mortality

Country-specific data source: No data
Method: Estimated from national incidence estimates by modelling, using incidence:mortality ratios derived from cancer registry data in neighbouring countries

Prevalence

Computed using sex-; site- and age-specific incidence to 1-;3- and 5-year prevalence ratios from Nordic countries for the period (2006-2015), and scaled using Human Development Index (HDI) ratios.

Summary statistic 2020

	Males	Females	Both sexes
Population	104 469 637	101 669 950	206 139 590
Number of new cancer cases	51 398	73 417	124 815
Age-standardized incidence rate (World)	98.8	122.5	110.4
Risk of developing cancer before the age of 75 years (%)	10.8	12.5	11.7
Number of cancer deaths	34 200	44 699	78 899
Age-standardized mortality rate (World)	70.7	79.5	74.8
Risk of dying from cancer before the age of 75 years (%)	7.8	8.5	8.1
5-year prevalent cases	87 397	146 514	233 911
Top 5 most frequent cancers excluding non-melanoma skin cancer (ranked by cases)	Prostate Colorectum Non-Hodgkin lymphoma Liver Leukaemia	Breast Cervix uteri Non-Hodgkin lymphoma Ovary Colorectum	Breast Prostate Cervix uteri Colorectum Non-Hodgkin lymphoma

The Global Cancer Observatory - All Rights Reserved - March, 2021.

Page 1

Fig 2.1: Prevalence of Cancer in Nigeria

(Source: Globocan, 2020).

2.1.3 Concept of Logotherapy (LT) and its Components

Logotherapy (LT) is categorised with humanistic and existential study of human behaviour (Ponsaran, 2007). LT is known as the third Viennese school of psychotherapy (Hatt, 1965). Adler elevated the will to control, Freud propounded the principle of experiencing pleasure and Frankl the desire of experiencing meaning (Boeree, 2006). Initially, LT was referred to as heightened study of human behaviour because of the Freudian concept of deepness in the study of human behaviour. The significance of the study of the psyche was to learn ordinary and oblivious frameworks inside an individual mind research yet of such stature that it enabled individuals to rise above this standard procedure (Pytell , 2003). LT is not actually equal to psychoanalysis in that its systems are less inquisitive (Frankl, 1959). LT depends on the future components of a patient's life, and significantly more unequivocally on the derivation one needs to achieve (Boeree, 2006). Frankl is of the assumption that acquiring meaning is a basic need required for proper adaptation. According to him, acquiring meaning, being objective and hopeful in life are required for stability. Thus, if one would achieve purpose and meaning in life, it is necessary to cope with tiring events and deadly diseases with meaning (Jamali, 2002). Logotherapy is a kind of psychotherapy that mainly focuses on the freedom of human in life. This approach believes that humans can endure meta pain and attain meaning of life. Hence, humans are able to choose meaning because they are free and can select different options (Mehrangiz *et al.*, 2012).

Logotherapy has roots from existential philosophical concepts and was introduced by Frankl (1984). According to Frankl, every person has a unique task waiting to be fulfilled in life and it is that person's responsibility to actualize its meaning. Frankl also believes that one can transcend suffering if one has a reason to live. For Frankl (1984), ‘he who has a why to live for, can bear anyhow’ (p. 97). Helping clients and people in general find meaningfulness in their lives has long been a concern of Frankl (1969, 1978, 1992, 1997). As Hillmann (2004) shows, meaning is a basic concept throughout Frankl’s thoughts on therapy and is the key to the mentally healthy self. If an individual searches for the meaning of life, he will not find it. Meaning emerges as one lives and becomes concerned with others. When individuals focus too much on themselves, they also lose a perspective on life. For Frankl, helping a patient who is self-absorbed by searching for

causes of anxiety and disturbance only makes the person more self-centered. Frankl (1969) suggested that the solution is to look towards events and people in which the client finds meaning. In concentrating on the importance of values and meaning in life, Frankl developed an approach called logotherapy (Hillmann, 2004; Schulenberg, Hutzell, Nassif, & Rogina, 2008). Four specific techniques help individuals transcend themselves and put their problems into a constructive perspective in LT. These include attitude modulation, dereflection, paradoxical intention, and socratic dialogue. In attitude modulation, neurotic motivations are changed to healthy ones. Motivations to take one's life are questioned and replaced by removing obstacles that interfere with living responsibly. In dereflection, clients' concerns with their own problems are focused away from them. Clients who experience sexual performance difficulties may be asked to concentrate on the sexual pleasure of the partner and to ignore their own. Similarly, paradoxical intention requires that patients increase their symptoms so that attention is diverted from them by having them view themselves with less concern and often with humour.

Guttmann (1996) considers socratic dialogue to be the main technique in logotherapy. It can be used to guide clients to find meaning in their lives, assess current situations, and become aware of their strengths. It is a series of questions that help clients arrive at conclusions about beliefs or hypotheses, guided in part by therapist perceptions of the client's misunderstandings. These techniques help patients become less self-absorbed and develop meaning in their lives through concern with other events and people. Some existential therapists object to Frankl's approach, which appears to them to emphasize techniques over existential themes (Yalom, 1980). They prefer to help individuals become more fully aware of meaning in their lives by looking for issues that interfere with the process of finding meaning. As the therapist and the patient engage in their relationship, and as the therapist works authentically at creating a caring atmosphere, those issues that trouble the client are shared and meaningfulness emerges from their work together.In LT, living and dying; freedom, responsibility, and choice; isolation and loving; meaning and meaninglessness are interrelated. They all deal intimately with issues concerning the client's existence or being-in-the-world. Engaging the client, showing therapeutic love, and involving oneself with the client are all ways of

entering the client's world. They show clients that they are not alone and that they can be aided in their struggle with existential themes.

Frankl (1969, 1992) and his colleagues (Fabry, 1987; Lukas, 1984) developed this different short-term approach because logotherapy makes use of techniques of attitude modulation, dereflection, and paradoxical intention an active and challenging approach is used. Furthermore, many logotherapists use socratic dialogue in assisting clients in finding meaning in their lives. Although logotherapy is used with traditional psychological disorders, particularly obsessive-compulsive neurosis, it is used specifically for noögenic neuroses, when clients experience little meaning in their lives, such as when they have too much leisure or abuse drugs. Such an approach may take only a few sessions or require several months of meetings (Hillmann, 2004). Counsellors, nurses, social workers, and clergy often do short-term crisis counselling. Common crises include dying, the death of a loved one, the loss of a job, sudden illness, a divorce, and similar life milestones. By combining helping skills with a knowledge of existential themes, mental health professionals may not only be empathic to the pain of their clients but also be able to help them examine their lives from different points of view.

LT depends on an individual's crucial importance. This adventure of criticality in life is proposed as a crucial enticing power (Frankl, 1959). Frankl brings up that this voyage of importance has no association with extraordinary quality or religion. It is by and by judicious to discover a reason for one's life or activities (Somani, 2009). Logotherapists don't endorse centrality to a patient, they rather depict the arrangement of importance so as to give the patient a feeling of achievement (Thorne and Henley, 2005). Also, LT considers as helping a patient discover importance for the length of their day by day presence (Frankl, 1959). In this experiment, LT helped cancer patients find the affirmed meaningfulness of their condition, likely explanations and a strategy rather than improperly attributing the ailment to someone else or thing.

Finding Meaning

LT is made out of three basic models. The fundamental dependable guideline is that life is significant in all conditions, even the most critical. The subsequent choice is that the enticing power basic is the longing to discover importance of life. The third

fundamental standard shows that mankind has the chance to pick its attitude even under states of unchangable torment (Frankl, 1959). Along these lines, Frankl exhibits that individuals can find importance through inventive, experiential, and attitudinal qualities (Hatt, 1965). Innovative highlights incorporate performing errands, for instance, painting a picture or keeping up a flowerbed (Boeree, 2006). Experiential attributes make it conceivable to meet another individual, for instance a partner or an individual from his family, or to encounter the world through a condition of receptivity, for instance, by perceiving the wonderful ordinary (Hatt, 1965). Attitudinal qualities talk about the likelihood of picking important decisions in states of despondency and pain (Gelman and Gallo, 2009). Frankl battles for everything to be pulverized by an individual while allowing him the chance to pick his attitude (Frankl, 1959). He concentrated on the way that individuals ought not endure unnecessarily, that all together important things were conceivable when enduring is inescapable. For instance, an individual suffering from a disease or who is living in an inhumane imprisonment would now be able to find criticality paying little respect to how mad their circumstance is (Hatt, 1965). Hopeless constructive reasoning suggests that individuals are set up for sureness in spite of the forsaken course of action of three. Frankl recognizes that all people will be acquainted with the shocking social affair of three individuals, which incorporates an unavoidable torment and tribulation (Ponsaran, 2007).

Frankl sees that the immensity of life changes starting with one individual then onto the next and starting with one circumstance then onto the next. In this sense, it takes the stand concerning the way that there is genuinely no broad criticalness in the life of the entire of humankind, yet rather a recommendation proposing that changes happen at a sporadic minute (Frankl, 1959). Frankl focus on himself the amazing idea of human closeness that recommends that every individual can discover reason and centrality by being created towards a person or thing other than oneself. Its concept of self-dazzling quality is identified with the believability of the super-immense (Hatt, 1965). Super-essentialness recommends an uncommon induction that outperforms the most profound and most smart cutoff points of mankind. Researchers regularly point to the probability that individuals will bear the irregularity of life. Frankl prescribes, in any case, that

people ought to rather be seen with the failure to get a handle on the huge idea of profundity, which is of principal significance (Frankl, 1959).

Existential Frustration

The desire of an individual to live in his embodiment may end up being forfeited. Frankl has propelled the term of existential disappointment to clarify this wonder of misdirected meaning. Existential bafflement can happen because of times of postponed weariness and absence of care (Zaiser, 2005). Frankl utilizes the likeness of an existential void to clarify the frustrated meaning. Non-pertinence is an opening that makes a void that must be filled. Since it is a void, things rush to fill the void of pointlessness. Regardless, most efforts to fill this feeling of chance are just succinct in light of the fact that transparency is stacked with shallow objects (Boeree, 2006). Also, Frankl perceived that common maladaptive practices, for example, discouragement, hostility, and fixation, came about because of a misled feeling of loss of meaning (Thorne and Henley, 2005). He found that every time had its own extraordinary arrangement of maladaptive practices, which it found to be absolutely awkward (Frankl, 1959).

The Noological Dimension

The term noölogical comes from the Greek word noös which demonstrates spirit or soul. More precisely, the noological estimate suggests everything that identifies with human estimation or the human sciences. Noological estimation is considered to be the domain of human full consciousness, obligation and the place of chance (Hatt, 1965). Frankl testified that animals only involve common and mental estimates, as they cannot equip themselves with the power of a self-knockout. In this way, Frankl declares that the psychological is set aside for instinctive repetitions. Similarly, since individuals are fundamentally the main species capable of transcending, they exist in the realms of natural, mental, and nonological estimates (Hatt, 1965). Existential frustration can lead to noogenic mental problems. Noogenic distress does not begin in psychological esteem but rather in noological estimation. Noogens mental problems do not emerge from conflicts between motivations and faculties, but rather from existential problems. Among these problems, there is the failure of the will to importance. Frankl observes non-sense discouragement when he sees patients who feel no desire to respond with repetitions that are unfavorable to themselves, others, and society. Frankl emphasizes that a person's

stress and anguish about the irrelevance of life is an existential problem and not a mental infection. Moreover, it testifies to the fact that people do not need to look for homeostasis for the duration of everyday life, but rather what Frankl has called noo-component. Noö-components suggest a persistent existential constraint. For example, in a state of polar weight, an axis is treated by a suggestion that will be completed by one individual and the other by the person who filled it recently. In this way, this means land of inner weight instead of internal parity (Frankl, 1959).

Presumptions of LT

All psychotherapies give rise to philosophical doubts about human individuals that cannot be stated with confirmation. LT's philosophical assumptions include:

1. The individual is a component containing a body, a brain and a soul.
2. Life has meaning in all conditions, even the most miserable.
3. People have a desire to meaning.
4. People have the opportunity under all conditions to start looking for meaning.
5. Life has a quality to which people must react in order for decisions to be remarkable.
6. The individual is incredible.

Logotherapy is a treatment process to achieve one’s ability and expand views towards ego, the surrounding world and issues that create the meaning of life (Ulrichová, 2012). The meaning of life is linked with values we live up to, values that we choose and decide upon. The lives of many people prove that we are not helpless victims of destiny. A person can be subdued by destiny as long as he clutches to one requirement that is not fulfilled, which consequently makes one lose appreciation of the bigger picture. The opposite of loss of meaning is a pursuit of wisdom. Wisdom means to live in a hopeful spirit (Frankl, 1985). Logotherapy refers to the meaning of human existence and emphasizes on the search for one’s resistance in regard to this concept. According to the principles of logotherapy, trying to find the meaning of life is the most fundamental driving force of every person in their life (Aghajani, Akbari, Khalatbari and Sadighi, 2018). Logotherapy, by taking into account the transience of human existence rather than pessimism and isolation, invites humans towards effort, hope and activity. It expresses that suffering and undesirable destiny aren’t the reasons for people’s failure, but that

failure occurs when life becomes meaningless. If we bravely accept suffering until the last minute of life, life will have meaning and the meaning of life can include even the potential meaning of pain and suffering. Humans against adverse conditions, risks and hardships often feel helpless and hopeless and, in many cases, they also try to accept risks and hardships, from which oftentimes unexpected results can be obtained.

Diagnosis of cancer can cause personality crises in people. At this time, many factors can contribute to patients overcoming their illness. A psychological intervention such as group logotherapy is a small world that symbolizes the real world in which the members participate with the aim of exploring themselves as individuals who have shared interests. This method is an explorative journey for achieving the ability to be with their true selves and expand their perspective toward themselves and their surrounding world and clarify what gives meaning to their present and future life (Ulrichová, 2012).

Logotherapy can help people with cancer to increase their resilience by adding more meaning to their lives. Creating meaning and logotherapy can be considered important in people's confrontation with life-threatening illnesses. Considering that recognizing and identifying the correct way to treat it are important aspects of care in cancer patients, logotherapy can be used as an effective way by mental health professionals along with other therapies to improve the hope and depression of affected people (Hassani, Emamipour and Mirzaei, 2018). About the role of meaning of life in logotherapy, Jaarsma *et al*. (2007) noted that the experience of the meaning in life was positively related to feelings of psychological wellbeing and negatively to feelings of distress. By creating the meaning in life, logotherapy leads to compatibility, life satisfaction and psychological well-being, adapt themselves with sadness, despair, and diseases.

Carl Rogers stated that Frankl's work was the most amazing commitment to the study of human behaviour over the last 50 years. Frankl tried the Freudian hypothesis by asserting that the path of importance is the basic motivation of the brand for humanity. He recognized that individuals were more than mechanical parts driven by instinctive impulses and that people could find the essentials even in the most terribly discernible conditions known to mankind. His terrible experiences in the Nazi Center, Frankl's underlying lucrative experiences with Adler and Freud helped him develop further. In the

same way, his experiences in severe detentions massively influenced his hypothesis of significance. Frankl realized that, despite the way he had been reduced to a mere skeleton, the Nazis could not retrieve his attitude from him. LT easily organizes reflections on religion, the search for the mind and reflection. Similarly, Frankl's LT contributed to the psychological composition of various neologisms, including various terms encompassing noological estimation. Similarly, Frankl has made feasible logotherapeutic interventions like the paradoxical intention. LT has stood the test of time because it has many applications in the advanced world. Viktor Frankl is a man who carries the tide of the tragic triad, has lost everything, apart from saying yes to life inspite of all odds. The researcher views LT as a viable psychotherapy that could help malignant patients become aware of their illness and concentrate on the strategies for managing it.

2.1.4 Concept of Cognitive Reframing (CR)

Cognitive Reframing was first conceived as a cognitive-behavioural therapy for depression (Beck) and as a bit of rational emotional behaviour therapy (according to Ellis' interpretation). Cognitive behavioral therapy (CBT) is an active, problem-focused, and time-sensitive approach to treatment that aims to reduce emotional distress and increase adaptive behaviour in patients with a host of mental health and adjustment problems. Cognitive behavioural therapists deliver interventions in a strategic manner, such that interventions: (1) emerge from the customized case formulation of the patient's clinical presentation, (2) are delivered in a collaborative manner with the patient, (3) are designed to move patients forward and directly towards meeting their treatment goals, and (4) are seen through in their entirety so that their efficacy can be evaluated with "data" collected by the patient. Thus, the basic strategies of CBT are efficient, focused, and targeted (Wenzel, 2017).

The basic premise of cognitive-behavioural theory (CBT) is that people can learn new behaviours to use in response to stimuli and that the thought processes that serve as an intermediate step between the stimuli and the behaviour can be altered, thereby, influencing tobacco-use cessation. Cognitive-behaviour theory (CBT) was developed from two theoretical streams behaviourism (behavioural theory) and cognitive theory (CT) using a theoretical model that was adopted and used as a treatment procedure as

shown in the figure below S O r R S = Stimuli Control, a method whereby cues (e.g., tip sheets on refrigerators) are provided to a person as a reminder of the desired behaviour (e.g. not using tobacco). O = Organism, which is the person seeking help to quite using tobacco. More specifically, it refers to internal processes such as thoughts and feelings. Influences at this stage include techniques designed to change how a person thinks about his or her tobacco use and to train that person to think differently about engaging in this behavior. This part of the model separates CBT from strictly behavioural approaches. R = Response. CBT seeks to modify or alter a person's responses. For example, a person can be taught new skills to help him put down a cigarette or find another activity to engage in when craving nicotine. R = Reinforcement, which is necessary to help the person continue performing a new behaviour (chewing on a toothpick) instead of the old behaviour (using tobacco) (Beck, 2005; Beck, Wright, Newman and Liese 1993).

Cognitive reframing, a dimension of CBT, is an incredibly amazing therapeutic method that has been modified to help people adjust to all the trends that can lead to disturbing events and disorders. It is a psychological strategy that tries to help people quit to have a pessimistic or overwhelming vision. Basically, the main idea here is that thinking about a condition is essentially more remarkable than the situation itself. In other words, when an annoying or disturbing event occurs, for example, the pathological disorder, the individual's reaction to the situation and his reflections are fundamental. Cognitive reframing therapy emphasises that emotional problems are a consequence of maladaptive thoughts and the goal of treatment was to reframe distorted thinking and to promote adaptive thoughts. The way individuals perceive and process reality will influence the way they feel and behave. Thus, there is the need to reframe and correct these distorted thoughts to promote behavioural change and ameliorate emotional disorders (Knapp and Beck, 2008).

Cognitive reframing is a talking-based therapy arising from the link between thoughts, feelings and behaviour. Central to cognitive reframing therapy is the belief that thoughts influence behaviours and feelings. Unhelpful thoughts generating the urge to engage in negative behaviours can be identified and challenged and that by replacing these thoughts with more realistic ones, behaviours and feelings can be changed.

Cognitive reframing treatments use techniques which challenge the illusion of control, randomness perceptions and other cognition errors. It has shown to be useful in many ways, such as when trying to improve memory, reduce anxiety and depression. It has also been beneficial in helping parents and children cope with disabilities. Lachman, Weaver, Bandura, Elliot and Lewkowicz (1992) concluded that problems could be solved by shifting perspective on the problem. Additionally, cognitive reframing has helped parents whose children have disabilities to change their negative view about their children (Woolfson, 2003).

Cognitive reframing is a technique used in therapy to help create a different way of looking at a situation, person, or relationship by changing its meaning. Cognitive reframing may be used to change the way people think, feel, and behave. Negative thoughts can be transformed through cognitive reframing. It is a strategy therapists often use to help clients look at situations from a slightly different perspective. It can be used in therapeutic settings as well as by individuals whenever distorted thinking or negative thought patterns are experienced. The essential idea behind reframing is that the frame through which a person views a situation determines their point-of-view. When that frame is shifted, the meaning changes. Hence, thought and behavioural patterns often change along with it. Another way to understand the concept of reframing is to imagine looking through the frame of a camera lens. The picture seen through the lens can be changed to a view that is closer or further away. By slightly changing what is seen in the camera, the picture is both viewed and experienced differently (Clark, 2013). Distorted thinking can cause psychological distress and contribute to mental health conditions such as depression and anxiety. Cognitive reframing, whether it is practiced independently or with the help of a therapist, can be a helpful way to turn problems or negative thoughts into opportunities for change and growth.

Cognitive reframing is one of the numerous techniques used by cognitive behavioural therapists to help clients become aware of the connections between their thoughts, emotions and behaviours. It is a central technique of cognitive therapy that teaches people how to improve themselves by replacing faulty cognitions with constructive beliefs (Corey, 2009). The overall intention when using cognitive reframing is to help clients move away from more extreme and unhelpful ways of seeing things to

more helpful and balanced conclusions. Clients can realize that life does not always work out the way they would like it but can be bearable (McLeod and McLeod, 2011).

McLeod (2015) asserts that clients learn to distinguish between thoughts and feelings by:

1. becoming aware of the ways in which thoughts can influence feelings in unhelpful ways
2. learning about thoughts that seem to occur automatically, without even realizing how they may affect emotions
3. evaluating critically whether these automatic thoughts and assumptions are accurate or biased
4. developing the skills to notice, interrupt and correct these biased thoughts independently, thereby leading to change in attitude, which also affect personality in a positive direction.

Cognitive reframing is a system of subjective treatment that helps patients to identify or recognize, evaluate or challenge and modify or change maladaptive thoughts and beliefs associated with emotional distress with more accurate and less rigid thinking inclinations. Techniques like behavioral activation, exposure and problem solving helps patients increase engagement in activities that provide a sense of accomplishment and pleasure, allows anxious patients to have systematic contact with feared stimuli and situations, overcoming avoidance and reliance on ritualistic behaviour to neutralize anxiety and teaches patients systematic skills for addressing life problems and overcoming unhelpful attitudes about problems. The underlying advance of CR is to filter and record events A, B and C on a thought record or graph containing parts or fields where each part can be freely recorded. It is fundamental to record things in order to think about it (Clark, 2013).

When thoughts become disputable, it is necessary to solve the following puzzles:

- Are my contemplations of the event accurate?
- What evidences are there to support my point of view?
- What are the elective points of view of the event?
- Do I really care about my ability to adapt to the event?
- What is the most horrible thing that can happen if my perspective on the event is correct?

- What movements would I have the opportunity to have to perform the event?
- What is the most terrible thing that can happen to my family and how does this event differ?

With regard to reflection for a certain time, the last task is to trace the main feelings with the aim that they are gradually defined and less distorted. This should be conceivable by truly changing the main thought in the section of effective thought or in the field of the recording of thought. Record better methodologies for logical support assumptions or feelings that lead to another approach to handling activating event processing. With the preparation, we will have the choice to begin to change the weight which affects useless examinations, and we will have a less constraining feeling and gain more happiness (Yurica and DiTomasso, 2005).

Cancer is a disease which affects the sufferer both physically and psychologically and this affects adherence to treatment. However, adequate proofs have shown that psychological interventions such as psycho-education, therapy in social support, cognitive therapy, training in coping mechanisms, guided imagery amongst others have shown to bring about a reduction in the level of pain the patients suffer, an improvement in sleeping patterns and appetite, a reduction in distress and anxiety levels as well as improvement in physical, mental and emotional wellbeing and functioning (Pandey and Vajpeyi, 2020). According to them, CR has proven to be a veritable therapy in the improvement of cancer patients' quality of life and experience because it assists them to exhibit positive outlook using available resources and making informed decisions despite the condition and struggle.

Cognitive reframing is a structured and combined psychological intervention that is used to identify the effect of patients' experiences based on their belief system. It helps to reconstruct thoughts and change responses through new skills and behaviours. It has been increasingly used among patients with chronic diseases to manage symptoms (White, 2011; Dennison and Moss-Morris, 2010) or improve psychosocial outcomes (Moorey *et al.*, 2009).

2.1.5 Concept of Social Support

The concept of social support has been defined and operationalized in different ways and is identified as important in adjusting to breast cancer (Holland and Holahan, 2003). It is a multidimensional concept that is generally theorized from a quantitative-structural perspective of social networks, such as numbers of persons and formal relationships with them, or from a qualitative-functional perspective of social support, such as the perceived content and availability of relationships with significant others (Nausheen, Gidron, Peveler, and Moss-Morris, 2009). Khalili, Farajzadegan, Mokarian, and Bahrami (2013) reported a link between social support and coping skills and confirmed that effective social support for breast cancer patients could help reduce the negative impact of diagnosis and treatment and promote their psychological well-being.

Social support is a generally sought structure in the study of human behaviour**.** It has been portrayed as the various kinds of support that individuals get from others. It is the physical and emotional solace that our family, our acolytes, partners and others offer us. It is perceiving that we are in a manner of arrangement of individuals who love and care for us and think about us (Fairbrother, 2011). Social support can be assessed in various ways. Emotional support comprises of an offer of compassion, love, trust, confirmation, closeness or solace. It implies the developments that individuals make with the goal that another person feels mulled over. It entails the brightness and nurturance given by the wellsprings of social support. Giving emotional support can allow the individual to comprehend that the individual is being considered. Additionally, it is to a great extent called support for regard or support for assessment (Wills, 1990). A significant part of the time, enormous, questionable stretches of social support are connected to the psychosocial reasons for ladies with cancer. Ladies' assessment of the level of overall social support they have acquired are closely linked to the degree of adjustment they experience (Lichtman, 1988). Also, ladies who experience a continuously expanding level of social support advantage increasingly move towards positive results and a littler negative effect (Funch and Mettlin, 1982).

Liberal support, otherwise called instrumental support, is the way towards helping through money, material, or associations. This kind of social support envelopes ground-breaking and direct approaches to help other people (Langford, Bowsher, Maloney and

Lillis, 1997). Organizational support is such kind of support that gives somebody the sentiment of having a spot in the public arena. This can be considered as the closeness of the accomplices with whom to partake in the social exercises presented (Uchino, 2004).

There are partitions between support seen and acquired. The support seen infers the beneficiary's hypothetical judgement that the suppliers will offer (or have offered) persuading help in an essential crossing point. The support acquired includes unambiguous support (reprobation or solace) offered by the suppliers during basic intersections (Uchino, 2004). Social support can be surveyed against support from a partner or accommodating support. Basic support (comparatively called social blend) shows how much a beneficiary is attached to a social setting, for example, the quantity of social associations or the converging of a person into their social setting. Family affiliations, acolytes and support in clubs and affiliations add to the social wire. Useful support appears to demonstrate explicit restrictions that individuals in social settings can give, for instance, to excited, instrumental, educational and the connection referenced above (Gurung, 2006).

Social support can emerge out of an assortment of sources including, yet not restricted to, family, mates, accomplices, pets, connections, and accomplices. Wellsprings of support might be standard (adored) in every conventional case (specialists in mental flourishing or affiliations to a framework). The support of a nostalgic adornment is identified with health benefits, particularly for men. Early family social support has been basic in empowering kids to create social abilities, and parent-providing care affiliations have additionally produced enthusiasm for school-created liners (Taylor, 2011). In upsetting occasions, social support enables individuals to lessen mental issues (strain or gloom). Social support has been found to contribute to progress in mental changes in states of high unending weight, for example, HIV, rheumatoid joint torment, cancer, stroke and coronary illness (Taylor, 2011). Individuals who have social support often report an increased sub-clinical reactions of despondency and anxiety than individuals with high social support. Also, individuals with low social support have a higher pace of mental pain than those with high support (Repetti, Taylor and Seeman, 2002).

A few theories have been proposed to show the connection of social support with health. Stress and the modification of social support theory situates the research on social

support and is proposed to clarify the cradle speculation. As the theory illustrates, social support shields individuals from the awful health impacts of extraordinary occasions by affecting how individuals intend to adjust and adjust to it. As the weight and the theory of alterations appear, the occasions are stunning to the degree that individuals have skeptical audits about the occasion and conform to it improperly. Alteration incorporates purposeful and wise activities, for example, essential reasoning or unwinding. Applied to social support, the theory of stress and alteration recommends that social support advances adaptable appraisal and change. The theory of weight and alteration of social support is affirmed by studies analyzing the effects of weight reduction for clear social support (Cohen and Wills, 1985).

Another theory useful in clarifying social support and health affiliations is the theory of life span, which features the separations among support perceived and received. As indicated by this theory, social support is far forward, particularly in youth relationship with guardians. Social support makes the qualities of adaptable character the nearest, for instance, a feeble accusatory disposition, a powerless neuroticism, a high good faith similarly as the social abilities and adjustment. Together, support and different parts of character impact health, everything considered, by driving health rehearses and taking out health-related stressors (troubles at work, autonomy). Proof proceeds, the theory affirms that an experienced support is trademark and that conspicuous support is related with versatile attributes and affiliation encounters (Uchino, 2009).

Social condition is an eminent region in the study of breast cancer (Helgeson and Cohen, 1996), in light of the fact that the breast cancer patient's experience is a breaking framework that influences social affiliations (Koehly, Peterson, Watts, Kempf, Vernon *et al*., 2003). Since breast cancer patients are profoundly influenced by the hurtful results of their malady, it is not astounding that their allies are influenced (Compas, Worsham, Epping Jordan, Grant, Mireault *et al*., 1994). A few researchers have considered the effect of a lady's breast cancer on her accomplice and her young youths, just as the impact of family relationship on the vitality achievement of cancer patients (Walsh, Manuel and Avis, 2005).

Regardless of the fact that almost no research has been done on the impact of family relationship on the burden eventually brought about by female individuals from

the group of bosom cancer patients. Life accomplices of ladies with bosom cancer can bring excited outcomes by observing the effect of bosom cancer on their life accomplices and their very own responsibilities to give required assistance. Furthermore, they become mindful of their expanded individual danger of bosom cancer, which can obstruct their longing to succeed, their support, their affiliations and their preventive health practices (Valdimarsdottir *et al*., 2005).

The disclosure, management and treatment of breast cancer happens in complex social settings. Ladies with breast cancer think about relatives, particularly colleagues or partners, to be especially basic; they give enthusiastic and important support, make requests and check for gigantic subtleties at gatherings, and help to settle on basic choices about treatment (Speice *et al*., 2000). Likewise, unprecedented family correspondence (Edwards and Clarke, 2004) and an extensive level of evident family support (Baider, Ever-Hadani, Goldzweig, Wygoda and Peretz, 2003) are identified with lower mental depression in patients with breast cancer. Family care requires both love and work; both character and improvement have unequivocal ramifications for the character and action of individuals (Graham, 1983).

Ceaseless work builds up this capacity among work and love, segregating between thought (down to earth support, for instance, dressing, washing, feeding, cooking or transporting) and thought (eager support, for instance, attempting to catch the sentiments of others, check issues, show appreciation and attempt to pursue or improve the mental advancement of others **(**Strazdins and Broom, 2007) calls this last sort of vivacious care work, contending that the management of emotions (altogether different and various individuals) is diligent work and qualified.

Albeit most researchers concur that, given all, ladies give more care than men, there is some inquiry with respect to whether care styles are sexual orientation explicit. For instance, Carroll and Campbell (2008) question the likelihood that offering thoughts to a man is constantly determinative, while giving a lady an idea keeps up family affiliations. In this point of view, Northouse *et al*., (2000) found that ladies (colon cancer patients and accomplices throughout everyday life) characterized a bigger number of issues than completing work, family and social occupations, and less conjugal coinciding than men. Associates in the female life were doing severely and finding less social

support from their loved ones than assistants in the male life. This might be on the grounds that ladies are more willing than men to discuss negative emotional states or due to the fact that they engage in multitude of tasks consecutively and go through elevated distress levels when faced with stressful conditions. Social support is critical for the survival and quality of life of chronic disease patients. The availability and accessibility of social support or otherwise significantly determines the prognosis and quality of life of chronic disease patients. Healthcare professionals and family members or significant others are major players in organizing social support for chronic disease patients. Aside from treatment and medication, social support according to research has shown to reduce anxiety, stress, fear, and other negative assumptions associated with being diagnosed with a disease condition and therefore, plays a critical role in the healing and treatment process of the disease condition. The availability of social support has proven to have a significant influence on not only the health of cancer patients but also on other aspects of life. Lack of the various types of support including informational, emotional, and tangible support affects livelihood.as lack of financial support can force patients to sell their belongings, reduce their self-confidence and self-esteem, and bring suffering on them (Adam and Koranteng, 2020).

Spouses should be encouraged to be involved in the management of their partner's cancer from the pre-diagnosis stages to the post-diagnosis treatment decisions. This can go a long way in improving how the disease is theorized and perceived, it can also significantly improve metaphors used to discuss the disease and the effects of these on the experience and management of the disease. Metaphors such as fear, death, deformity and witchcraft associated with breast cancer impact understanding of the disease and whether or not women seek medical treatment (Sontag, 1997).

Social support has been found to be correlated with positive treatment outcomes for many chronic conditions including breast cancer, and it significantly reduces the stress emanating from cancer diagnosis as well as improves emotional wellbeing**.** Social support is described as support received in the form of information or a tangible item and emotional suppor; or the sources of support (family or friends) that enhance the recipients' self-esteem or provide stress-related interpersonal aid (Kim, Han, Shaw, McTavish and Gustafson , 2010).

2.1.6 Concept of Self-Efficacy

Self-efficacy as a concept implies having the opportunity to imagine doing what is needed to reach the required level. As demonstrated by Bandura, self-efficacy suggests to people the emotions they feel about their own abilities to perform a viable technique that achieves a perfect result. A high degree of self-efficacy appears to be a very good indicator of the results obtained in all regions. Broader self-efficacy is accompanied by renewed normal motivation, the ability to support organized levels of motivation and achievement, enthusiasm for problems, and better basic reasoning (Bandura, 1977).

As Bandura shows, individuals (in this case cancer patients) whose sense of effectiveness has been increased, set higher needs, manifest a fundamental flexibility more and more evident in the mission of the game plans, achieve more insightful performance and are logically accurate, evaluating the idea of their presentations that proportional cognitive limit patients who were convinced that they needed such abilities. It testifies that the most "particularly human" limit is that of self-reflection, which makes it an undeniable element of social cognitive theory (Bandura, 1986).

According to Bandura *et al.* (1987), through self-reflection, people capture their experiences, seek their own personal perceptions and feelings, participate in self-evaluation, change reasoning and lead in the same way. In this sense, he evoked the large number of examinations that have an impact on human work and remain exceptionally central to social cognitive theory, are feelings of personal effectiveness, for example the choice of people as to their ability to manage and execute the approaches required to achieve relegated objectives. The feelings of self-efficacy, as demonstrated by Bandura, ground human motivation, achievement, and singular achievement. It also means that if people recognize that their exercises can produce the result they need, they have significant strength to act or continue even with difficulties.

The key debates of Bandura (1997) regarding the confidence activity in self-efficacy in human work are that people's level of inspiration, passionate state and exercise are highly dependent on the things they recognize than that which is substantially impartial. In the same vein, the way people act can be regularly better anticipated by the feelings they have about their abilities than by what they are really able to accomplish, because the perceptions of their own effectiveness make sense of what individuals are

doing with their learning and skills. . This explains why social order practices are largely isolated from their real abilities and why their direct methods can differ widely on any occasion when they have similar data and skills. Various competent individuals persevere in incessant and sometimes debilitating scenes of questioning their abilities obviously. Likewise, a similar number of individuals are certain of what they can accomplish by not caring to accumulate unpretentious skills.

Schunk (2000) argues that greater self-efficacy and interest are linked to the use of increasingly powerful cognitive systems, such as elaboration, reformulation and control status. Self-efficacy in this sense, according to Pajares (1996), confers on a person the assurance of performing a specific task in a sustainable way, and is associated almost with task commitment, coherence and consistency production. Bandura (1997) suggests that self-efficacy is an emotion to successfully execute the necessary course of action to achieve a perfect result. While different studies reveal that cognitive skills affect feelings of effectiveness, Bandura (1999) argues that cognitive abilities are not just an impression of efficiency. He points out that studies have shown that adolescents with comparative cognitive skills differentiate in their academic presentations depending on the nature of their clear self-efficacy. In the same vein, Bandura (1999) argues that self-efficacy is an unrivalled indicator of insightful execution. This point of view testifies to that of Multon, Brown and Lent (1991) according to which a great self-efficacy is a very strong marker of success.

Self-efficacy theory posits that the greater a person’s confidence is in his or her ability to execute a course of action, the higher the probability that a desired goal will be attained. This high confidence, or perceived self-efficacy, is based on judgments that a person makes about how well he or she can perform certain behaviors required to manage or cope with prospective situations (Bandura, 1989). Peoples’ beliefs or expectations regarding their ability to exercise control or mastery over their behaviors represent a central and pervasive mechanism of human agency, which plays a major role in goal seeking and attainment. Patients with higher coping self-efficacy are more likely to engage in effective strategies and demonstrate greater persistence in trying to achieve desired psychosocial outcomes such as better adjustment and quality of life and medical

outcomes which include fewer or less intense symptoms and side effects as compared to those with lower self-efficacy (Bandura, 1986).

In the context of health and illness, self-efficacy expectations are a part of a general process of self-regulation. People with high self-efficacy expectations for coping are better able to engage the resources needed to meet the challenges involved in coping with stressors compared to those low in self-efficacy (Bandura, 1991).With respect to improving health in non-cancer populations and coping with illness, high-efficacy expectations have been associated with adherence to exercise regimens (Anderson, Wojcik, Winett, and Williams, 2006), successful weight control (Linde, Rothman, Baldwin and Jeffery, 2006) adaptive coping with pain (Litt, 1988) adjustment to rheumatoid arthritis (Beckham, Rice, Talton, Helms and Young, 1994) and smoking cessation (Yzer and Van-den, 2006). In general, individuals with higher self-efficacy report fewer problems associated with psychological distress and demonstrate greater persistence in working towards attaining specific goals than those with low self-efficacy.

Research in psychosocial oncology suggests that self-efficacy plays a significant role in patients' ability to cope with stress related to their cancer diagnosis and treatment (Cunningham, Lockwood and Cunningham, 1991). Studies have suggested that those cancer patients who feel more efficacious in their ability to cope are better adjusted (Lev, Eller, Kolassa, Gejerman, Colella , *et al*., 2007), enjoy a higher quality of life (Giese-Davis, Koopman, Butler, Classen, Morrow and Spiegel, 1999) may live longer (Merluzzi and Nairn, 1999) and experience less depression (Weber, Roberts, Resnick, Deimling, Zauszniewski, *et al*., 2004) than those who feel less confident in their ability to cope.

Cancer as a chronic illness requires management over a longer period of time. A patient's health beliefs and self-efficacy can play a large role in the successful management of the psychological and physical tolls of cancer. Self-efficacy in this regard is the theorized level of confidence a patient or their caregiver may have in managing some of the psychological and physical sequelae of active cancer treatment. Patients with measured higher levels of self-efficacy tend to be able to better self-manage their chronic illnesses (Foster *et al*., 2014). These patients are more self-aware of the care needed to continue moving forward and actively participate in the decision-making process in addressing the sequela of cancer treatment. Patients who are able to successful self-

manage make decisions to enhance and maintain their quality of life, ultimately leading to better health outcomes. Patients who have higher levels of self-efficacy have higher levels of belief that they can alter and change their health behavior in order to promote certain outcomes.

Self-efficacy is a widely used theory to describe how a person's confidence and beliefs frame the actions they take to create solutions to problems they face. In the application of this social cognitive theory to patients with chronic illnesses, self-efficacy beliefs have a major influence on how motivated patients are in complying with a treatment plan. A patient's self-efficacy level is their willingness and motivations to be able to make the outcomes they want and have the confidence to take the actions they need to complete. Previous survivorship studies have shown that patients feel more confident that they can make the necessary decisions in their own healthcare choices when they receive adequate information about their previous treatment and expectations of what is to come in the future (Lam, 2019).

2.1.7 Health self-efficacy

Health self-efficacy is a direct indicator of purpose and attitude. As indicated by social cognitive theory (Bandura, 1997), an individual who has a perceived mode of control is capable of engaging in behaviours that are healthy. It turned out that strong individual effectiveness was associated with better health, better fulfilment and dynamic social support. This concept has been utilised in places as varied as academic success, physical and mental health, decision-making in career and relating to socio-political change. It has emerged a key variable in health care, academic, community-based, formative, health and character science (Bandura, 1992).

Desires for results and feelings of effectiveness recognize extraordinary occupations in controlling health, trying their luck, generating negative affinities and dealing with progress. By taking control of an ideal lead, people first structure a goal and thereafter strive to perform the task. The end desire is a huge predictor of improving needs, but they are less so, everything is considered and controlled. Self-efficacy, again, is clearly sincere in both the self-determination times of health. Positive results want the choice to change initiative. From there, the desires of result might be unimportant, given

the way this other question is created, to express the authentic presentation of the track and its support. At this point, self-efficacy continues to be a dominant impact.

The perceived self-efficacy of health tends to the belief that risky health practices can be modified by valuable development, for example, by using one's abilities to limit attractiveness. Direct change is perceived as a threat to the apparent ability to conform to one's weight and exhaustion, as well as to identify points of interest and game plans to meet the needs of the situation. Effectiveness-related emotions influence the purpose of direct chance change, the amount of effort that is used to achieve that goal, and the consistency of continuing to strive despite obstacles and challenges that can undermine inspiration. Perceived self-efficacy has evolved into an applied theoretical structure applied to models of dependence and breach of trust (Marlatt, Baer and Quigley 1994). This view recommends that to acclimatize to high risk conditions is almost entirely dependent on how individuals feel that they are working as one of their own experts and are directing their own abilities to regain control in the event of a risk.

Self-efficacy for health is linked to the notion of control of one's state and one's main role. Feelings of self-efficacy in the face of health are recognitions that determine whether the change in the health thread begins, how much effort will be exhausted and how much will be sustained despite preventive measures and dissatisfaction. Self-efficacy has an impact on the effort we make to change dangerously directly and on creativity to keep striving despite obstacles and events that can undermine inspiration. Self-efficacy is immediately identified with the health manager, and in any case, it also influences health practices by having effects on goals. Self-efficacy has an impact comparable to that of set goals (for example, "Intention to reduce my smoking" or "I want to stop getting rid of my supreme power"). Persons with intense self-efficacy select all the test goals. They revolve around conditions, not entanglements. (DeVellis and DeVellis, 2000).

As the theory of planned behaviour shows (Ajzen, 1991), need is the most proximal marker of lead. Learning points that affect a particular point are views, enthusiastic norms and social control (recognition of the choice to play a particular live). Self-efficacy and social control are considered in relation to all synonymous plans and objectives. Nevertheless, self-efficacy is identified much more decisively with its

inclination and future direction. As suggested by the hypothetical Trans model (Prochaska, Norcross, Fowler, Follick and Abrams, 1992), self-efficacy and positive and negative outcomes are considered as the fundamental socio-cognitive factors that change over time. Self-efficacy is ordinarily low in beginning events and augmentations when people proceed ahead to the later stages.

The modifying effectiveness identifies the change of confidence according to the abandonment of the confidence urgencies. Once an innovative effort has been made to stop, there is reference to a complete maintenance of the negotiation. At this stage, the weak are confronted under very favorable conditions, for example if they encounter negative effects or seductions under positive social conditions. The oversights are likely to occur unless the waste of time allows for optional modification strategies. Believing in its changing stock helps to choose even moderate decisions and to start adaptable change reactions. Stay away from the trust-destroying action that prepares the targets using a modified circumstance procedure that enhances modification efficiency (Gruder *et al.*, 1993). It also solidifies as cognitive modes of change.

The self-efficacy of the recovery is clearly identified and its efficiency evolves, but the two points of view are alternated within the support engineer (as the obstruction capacity and the malice are weakened by the self-efficacy in the adjustment action). If a pass occurs, people can fall prey to "the influence of the violation of the restriction", attributing their stealthy past to the inside, to suffering and to general causes, taking advantage of the opportunity and unraveling as a total loss of trust (Marlatt and Gordon, 1985). Be that as it may, the very self-accommodating people maintain a strategic distance from this impact by making possible a high-threat situation and discovering approaches to manage the control of wickedness and restore confidence. The self-efficacy for recovery of the limitation after a frustration essential has made it possible to advance the complete maintenance of the markets. Clinical intercessions revolve around recovery approaches after misfortune, for example, by monitoring and redistributing the condition, modifying elective modification strategies, causing a concise action plan for recovery (re-establishing commitment at an appropriate time) to stop, to start social support, to reframe the departure as a normal opportunity in a valuable learning process) (Curry and Marlatt, 1987). This restores self-efficacy and returns quickly to the

maintenance technique. Be that as it may, Haaga and Stewart (1992) found that the self-efficacy of recovery, not high but moderate, gives the best rates of consistency.

A number of studies on the adoption of health practices have measured self-efficacy to assess its potential influences in initiating behavior change. Whereas general self-efficacy measures refer to the ability to deal with a variety of stressful situations, measures of self-efficacy for health behaviors refer to beliefs about the ability to perform certain health behaviors. These behaviors may be defined broadly (healthy food consumption) or in a narrow way (consumption of high-fiber food) (Luszczynska and Schwarzer, 2003). Poor compliance with recommended treatment may result partly from patients' experience of adverse side effects, but it may also be due to a lack of self-regulatory skills. Considering psychosocial factors, adherence is related to lack of social support and lack of self-efficacy beliefs about one's ability to adhere to medication (Catz, Kelly, Bogart, Benotsch and McAuliffe, 2000). Also, Molassiotis *et al.* (2002) have found that adherence to antiretroviral medication in patients with HIV was strongly related to selfefficacy (that is, optimistic self-beliefs about the ability to follow the medication regimen). These self-beliefs, together with anxiety and nausea, were related to adherence to the recommended treatment. The relation between social support and medication adherence was weaker than the relation between self-efficacy and medication adherence. Low adherence self-efficacy, together with low outcome expectancies regarding the benefits following the treatment regimen, have also been found to be related to low medication adherence in HIV symptomatic women or women with AIDS (Murphy, Greenwell, & Hoffman, 2002).

2.2 Theories

2.2.1 Theory of Blame Attribution (BA)

The theory of attribution is a territory of research in social brain sciences depending on the founding works of (Heider, 1958), developed by (Jones and Davis, 1965) and (Kelley, 1973). Attribution specialists are social clinicians who are concerned about general procedures describing how and why individuals attribute the attributions they make. He will probably recognize the conditions which will lead an observer, through an assignment procedure, to transform a conduct, an opportunity or a result into

an internal attitude of the specialist in question, instead of a natural condition. Consequently, attribution is a judgment implanted in the perspective of the observer and subject to the epistemic condition of it.

Other work on attribution theory has focused directly on the issue of blame (Weiner 1995). There are distinct differences distinguishes between cause, duty and guilt. For a given negative result, the cause is characterized as an insufficient but essential part of a condition itself. The right motivations that speak of human organization are important for the theory. It is quite conceivable that individuals assume characteristic duties and even blame creatures or lifeless people. However, to do this, they must focus on additional human characteristics, in as much as it would be the same as imagining it as a human specialist from the perspective of the theory. Duty is a broad term with some detections. There is an allusion to the enthusiasm generated by this procedure as a good responsibility, especially with regard to the legal responsibility, the duties of an appropriate office or a mental / passionate limit.

Blame is an ethical judgment that stems from the responsibility of an ethically indefensible result, which could however be alleviated by legitimation or reason. The Shaver award procedure begins with a result that has been taken on a negative answer and evaluates an included operator for assignment of duty against five elements of responsibility, namely: causation, deliberation, intimidation, gratitude and premonition. The razor procedure is consecutive in its evaluation. (Schultz and Schleifer, 1983) argue that a judgment of responsibility presupposes a judgment of cause. Although Shaver raises the fact that the judgment of duty may be motivated absolutely by a compelling need for responsibility, without an association of cause and effect, its model of attribution confines itself to the rule that any obligation is imputed to a judgment of cause.

Shaver (1985) describes waiting as a deliberation size with a purpose determined on one side and automatic on the other. He describes it as the central concern in the assignment of duty and the case in which a judgment of purpose should lead to the most well-founded judgment of obligation. Nevertheless, there are exemptions in pressure and appraisal decisions. Bullying captures the power of another specialist, which limits socially accessible decisions for the operator being referred to. This may be due to an

immediate risk or positional relationship. In Shaver's model, constraint becomes perhaps the most important factor right after deliberation has been established. It only covers the impact that incites a duty of conscience. A forced specialist is assigned fewer functions than a specialist who acts deliberately without constraint.

To the extent of gratitude, the tax collector decides whether the specialist being addressed has the ability to understand that the result being referred to is ethically distorted. In case the specialist does not have such a limit, at that time anyway, he would assume certain obligations, but would be held responsible. Foresight is characterized by the extent to which the specialist knew that a specific activity would produce a specific result, preceding its execution. Likewise, with all the parts of this procedure, it is the tax collector's assessment of the information available to the operator that is evaluated. Prescience can also be the judgment of the perceiver of what the specialist should have learned. Without purpose, clairvoyance is transformed into an inquiry into the obligation to drive. Shaver assigns fewer assignments to a specialist who should have known than to a specialist, and less to one or the other than to an operator in the cases specified above. Attribution theory has directly focused on the subject of attribution of blame. He will probably recognize the conditions that will lead a perceptible person through a procedure of attribution to a property, behaviour, opportunity or result to an internal behaviour of the operator in question, instead of a natural condition. The theory of attribution differentiates the cause, the obligation and the guilt. This individual property duty and even blame creatures or lifeless beings, but in doing so, they should focus on additional human characteristics, as it would be the same as imagining that it was about a human operator from the theoretical point of view.

2.2.2 Mao and Gratch Computational Model of Attribution

Mao and Gratch (2005) have developed a computation model of the task of the obligation which models the decisions of the attribution factors according to the components of causality, deliberation, pressure and learning and the attribution of the blame after those decisions. It does not manage giving room for reasons for engaging in the behaviour, so that blame stems directly from duty. In Mao's model, actions are coded using multilevel plans. Non-brutal actions may have different deteriorations, indicating

elective ways of performing the action. The actions have preconditions and propositional impacts, as well as openings to demonstrate to the operator who was able or realized the action and to the specialist under whose power the action falls. Informative occasions are modelled as a succession of speech acts (Searle 1969) speaking of enlightening, mentioning and exchanging. Mao describes many derivation decisions that associate these representations and qualities with the attribution factors that determine how each included operator makes a decision about each negative outcome. Causality is discovered by the execution of the gross action that has resulted in the outcome. For waiting, a critical qualification is made between act and goal of result (Roesch and Weiner, 2001). It is expected that a specialist will plan any action or request made by the person in question.

In all cases, the objective of demonstration implies the objective of a result, and not of the majority of the results. At the moment when an action presents numerous potential deteriorations and the powerful specialist is authorized to choose the degradation, the objective of result passes from the requesting operator to the expert if all the decays do not cause the negative result. The constraint is assumed from the demand exchange. An operator who asks another to play an action shows that he is compelled to act and that it results in intimidation, depending on the decision of the enforcement specialist to respond to his requests. The standards applicable to the outcome decision require a similar logic with regard to the result objective, with the additional limitation that an operator with a prior objective is not compelled to be asked to do what he or she does had previously proposed. The premonition is clearly inferred by matching the result information with another operator before the action is executed. It is also suggested by purpose, because we cannot plan what we are unconscious. Mao's work represents a significant advance in BA modeling. Be that as it may, there are three restrictions: first, as Mao (2006) observes, she uses Boolean qualities for attribution factors, while attribution theory describes the elements of scalar qualities. Second, all blame is given to a solitary specialist (or to the meeting of the operators in a joint action). This is in conflict with human information in Mao's own analysis. Third, the manager's level of guilt is limited to a high risk estimate of deliberate action and a low risk estimate with no expectation. These assignments do not coordinate with human information.

2.2.3 Theory of Reasoned Action (TRA)

TRA was defined by Ajzen and Fishbein in 1980 in their mission of assessing the disparity of attitude and behaviour. According to this model, the conduct of an individual is dictated by his purpose of engaging in it. The theory predicts conscious behaviour since the conduct can be intentional and organized. This goal is itself dictated by the attitudes of the individual and his abstract norms towards behaviour. The parts of the reasoned action theory are three general developments: Behavioural Intention (BI), Attitude (A) and Subjective Norm (SN). This is condensed with the associated condition: Behavioural Intention = Attitude + Subjective Norms. Theory of reasoned action recommends that the conduct of an individual be controlled by his expectation to reproduce it and that this objective is an element of his attitude towards conduct and his subjective standard (Ajzen and Fishbein, 1980).

2.2.4 Theoretical Framework

This study is anchored on the Health Belief Model (HBM) propounded in 1952 by social analysts Hochbaum, Rosenstock, and Kegels working in the US General Health Services to clarify the reluctance of individuals to receive and participate in counter-medical procedures, action and screening programs for early detection of infections. HBM is a mental model that strives to clarify and anticipate health practices. It works by focusing on people's attitudes and beliefs. HBM was the subsequent theory that clarified this lack of cooperation in preventive practices and in patients' responses to indications and consistency with drug treatments. HBM proposes that an individual's confidence in the viability of a prescribed health action anticipates the likelihood of the person receiving the conduct (Lamorte, 2018). It is accepted that individuals make a gesture either to avoid, or to track or control ill health conditions, in case they consider themselves helpless to the condition and accept that the condition produces real results.

As the model indicates, the apparent weakness of an individual with respect to a pathology, the severity of the pathology, the impression of the efficacy and benefit of any proposed action will be effective on the health behaviour suffered relating to the pathology. It focuses on unique beliefs and attitudes that drive the search for health solutions for diseases such as tuberculosis and cancer (World Health Organization,

2014). HBM depends on the understanding that an individual will undertake a health-related approach, for example by seeking treatment if he or she feels that a negative health condition like cancer can be monitored and treated. For example, when a person is anxious that by making a suggested move, it avoids a health problem to the contrary (the use of a condom will be a powerful way to fight HIV) and agrees to actually make a prescribed move (he/she can use condoms with comfort and trust).

The health belief model proposes that individuals' beliefs about health issues, the benefits and limitations of action, and that self-efficacy clarify their commitment to health promotion (Janz and Becker 1984, Rosenstock 1974). It recommends individuals to choose their health decisions based on their apparent powerlessness to the disease, the apparent severity of their illness, their impression of the benefits versus expenses and their signs of action (Glanz, Rimer and Lewis, 2002). The HBM highlights four observations as the main constructions of the model: defenceless, seriousness, benefits and obstacles. It is according to need that these concepts represent the "preparation to act" of individuals. Various versions have been added to the HBM after a certain time: incentives to action that will activate this preparation and animate a clear conduct; and self-efficacy or self-confidence in the ability to effectively perform an action (Glanz *et al.,* 2002). Rosenstock *et al.* in 1988, included the latter two developments to make it easier for HBM to adapt to the challenges of constantly changing health-damaging practices, such as physical inactivity and smoking.

The benefit or cost ratio refers to assessing the viability of different actions that could be undertaken to reduce the risk of disease or the burden of disease (Glanz *et al.,* 2002). In general, individuals benefit from healthier practices when they agree that the new conduct decreases their chances of developing the disease. For example, individuals accept that the suggested action of visiting a cancer centre will improve their health status, possibly by enabling them to get treatment early or by preventing a decline in their health status. Seriousness refers to a person's beliefs about the reality or severity of an illness. Although the vision of reality is often based on medical data or information, it could also stem from beliefs that an individual has that an infection will cause or the impact it will have on his life (McCormick-Brown, 1999). As noted by Glanz *et al.* (2002), an apparent barrier incorporates undeniable costs that may affect the choice to

seek care. In the same way, it incorporates interfering with passionate, monetary, social and physical variables that can prevent a person from seeking care. Dennill, King and Swanepoel (1999) explained that HBM is a conceptual system for describing a client's behaviour in health promotion and illness. They further express that HBM describes an individual's health behaviour as a result of his belief. Social analysts explained that HBM's goal was to systematically clarify and predict preventative health behaviours by uniquely highlighting the link between health care practices, practices, and health administration practices (Walker, Holling, Carpenter and Kinzig, 2004).

The link between the health belief model and this study is that the choice of an individual to take a health decision is controlled by his or her belief about the health issue, its apparent benefits, and the barriers to action. As the model of health belief indicates, the attribution of cancer patients' responsibility to the disease is dictated by their beliefs about the disease and the belief that the danger will be diminished by a particular change in their health behaviour**.** The main ideas of the HBM are perceived sensitivity, perceived severity, perceived barriers, perceived benefits, self-efficacy, and cues to action. This model emphasize the need for individuals to have the belief that they can be sick even when there are no apparent signs and symptoms of a disease on them. It therefore, advocates for people to seek early medical check-up as a means of early detection or diagnosis, prevention and treatment of a disease as the case may be. This is very important particularly for cancer, as two third of all cancers can be prevented, treated and cured if there is early detection of its signs and symptoms. Therefore, under this model, health education is important, as it would allow individuals to develop attitudes of perceived sensitivity, perceived severity, perceived barriers, perceived benefits, self-efficacy, and take necessary actions to check their health status (Rahmati *et al.*, 2012; Glanz, Rimer, Viswanath, 2008; Yilmaz, Bebis, Ortabag, 2013 and Yucel, Orgun, Tokem, Avdal, Demir, 2014).

2.3 Empirical Review of Literature

2.3.1 Blame Attribution (BA) and Cancer

By trying to understand and adapt to their condition, causal attributions arising from causal beliefs for their illness by people with cancer can affect their psychosocial adjustment. Most survivors of cancer (78.2%) in a study of survivors of cancer who contemplated causal attribution recognized at least a cause. In addition, the lifestyle and organic elements were normal, although the mental components are less normal, with some varieties by cancer type. After multivariate modification, only the type of cancer was associated with the distinction of adjustable causes. Individuals that wondered "why me" (47.5%) were younger and had more details on a larger number of cancer-related issues. Most cancer survivors announced explicit causal attributions and many thoughts about "why me". Findings of the study suggest that the understanding and evaluation of causal attributions and the widening existential inquiries about determination may help in understanding survivor adjustment and psychosocial development (Ferrucci, Cartmel, Turkman, Murphy, Smith, Stein and McCorkle, 2011).

Freitas and Weller (2015) in a quest to find out why the delay of patients and the system affect treatment of breast cancer patients in developed and developing countries discovered that apart from decreasing survival rates among patients, not attributing the symptoms to cancer, fear and low level of education were very common reasons for delay of patients.

Sarki and Roni (2019) while highlighting some age long myths and misconceptions about cancers in the Northern Nigerian region, discovered that the most common myths and misconceptions about cancers in Northern Nigeria are that people get cancers from mystical sources originating in the forests or bush (these are mystical forces from the forests or bush known as ‘jeji’ or ‘daji’) and that western medication or hospital treatment worsens cancers as patients are likely to die prematurely when taken to hospital. Hence, some communities in Northern Nigeria are against taking patients with cancer to hospital and reluctant to seek hospital-treatment for their loved ones instead, they turn to trado-religious therapy. The extent of these beliefs is also manifested among educated individuals in the region who subscribe to this

misconception. Affected individuals are only taken to the hospital when the cancers are at an advanced stage, and trado-religious remedies have proven ineffective.

There are also widely held misconceptions that witchcraft can be used to transmit cancers to people and the people who believe witchcraft mediates disease causation do not seek treatment at hospitals or health facilities. Some communities believe that public "naming and shaming" of the perceived witch remedies the bewitched person's ill health. However, many people resort to other means, including trado-religious interventions. Thus, they concluded that understanding the traditional beliefs and local perceptions of non-communicable diseases is very valuable for informing sustainable and effective interventions. Therefore, the only remedy is approaching religious leaders for prayers in tandem with visiting traditional herbalists, who use local herbs, shrubs, or a mixture of both. In some communities, people do not even mention jeji when describing the illness, for fear of being the next victim or offending the perceived mystical forces.

While exploring the factors influencing the health-seeking behaviour of women with advanced breast cancer from the time they observed breast changes until the time of presenting in the hospital for care, Ogunkorode et al (2021) discovered that delays in seeking medical care after becoming aware of breast symptoms may lead to an advanced stage of the illness at diagnosis and a shorter survival time. Using the thematic analysis of the participants' interview, most of the participants in this study had the belief that breast cancer was a disease inflicted by the enemy, a spiritual attack which could also be inflicted by a traditional practitioner at someone else's request, also called an arrow especially when there are "no traces" of breast cancer in their family history, it could also be as a result of envy from people in one's environment. Patients do not seek hospital treatment because traditional healers and spiritualist also have the power to counter a spiritual attack. Such practitioners would return the arrow to the sender through prayers and other remedies. Hence, the need to explore and find ways to encourage women to seek prompt medical evaluation and management of breast cancer symptoms.

Ezeome and Anarado (2007) in their study also found out that many patients perceived cancer to be caused by spiritual forces, which can only be cured by traditional

healers because western medicine has been seen to be ineffective in managing such illnesses. This perception was often fueled by the fact that most of cancer patients die even after receiving orthodox western medical care. Therefore, to secure all the possible benefits and make sure they are not losing out on anything that might help in managing their breast problems, the people try alternative treatments first or use them in combination with western biomedical practice.

Mdondolo *et al.,* (2004) found that women in Xhosa, South Africa, preferred using traditional medicine to treat breast diseases, because it is less painful, does not involve incisions and can be completed quickly compared with western medicine. Similarly, Wright (1997) found that black breast cancer patients in South Africa discontinued biomedical treatment for the disease to seek traditional treatment due to trust in traditional medicine as more appropriate and less harmful. The women also felt their privacy was secured when using traditional treatment for breast cancer as opposed to western medicine where the cancer ward is open and accessible to the public.

CleggLamptey et al, 2009 found that over 60% of breast cancer patients in Ghana do not know anyone who has survived the disease . This fear causes most women in Sub-Saharan Africa to live in denial of their risks of the disease and evade or delay treatment (Ajekigbe, 1991). Also, in a study carried out by Fapohunda *et al.,* (2020), while reviewing cancer presentations patterns at a private cancer care facility in Lagos, Nigeria, their results show a high rate of cancer presentation at the late stage. The adverse cancer outcomes were attributed to lack of cancer awareness and poverty amongst other factors. It was also discovered in the descriptive study that 75% of patients presented late (Stages 3 and 4), 97% presented with symptoms, which can be an indication of advanced disease and symptomatic presentation also increases cancer-related morbidity and mortality.

In most developing African countries, most patients present with late diseases when only palliative care remain the only option of management, resulting from delay presentation, (Adeoti *et al.*, 2016) this coupled with delay initiation of definitive treatment worsen patients' prognosis and outcomes. Akanbi et al, 2015 outlined the response of females visiting hospitals for various reasons on their knowledge about breast cancer which demonstrate their paucity of knowledge about breast diseases with

some of them quoting phrases like "breast cancer is nemesis for promiscuous female, breast pain is the hall mark of breast cancer, is a disease of large breasted female, is an incurable disease". Even those with previous knowledge about breast cancer were not adequately informed.

In a study by Eke, Ugwueze and Akani (2021) while observing the trends of childhood cancers in a tertiary centre, it was concluded that 33% of the study population patronised traditional and herbal medicine practitioners and or churches before presenting to the hospital. This practice which is common in the country, is worrisome as can be associated with late presentation which can compromise treatment outcomes (Brown and Adeleye, 2017). Cultural practices and beliefs have immense impact on the delayed orthodox medical treatment of cancers in our society (Saeed, Asim and Sohail, 2021). In India, a study demonstrated that the majority of the people thought that cancer was because of curse, evil eye or as a result of past sin (Kishore, Ahmad, Kaur and Mohanta, 2008). Another study in Nigeria also reported that women believed that wizardry, multiple sexual partners and inserting herbs into the vagina cause cervical cancer (Issa-Modibbo, Dareng , Bamisaye et al, 2016).

Patients seek various forms of treatment before, during and after orthodox medicine, as reported in several African studies. (Binka, Nyarko, Awusabo-Asare, and Doku, 2018) reported that patients employed numerous active and avoidant strategies to cope with their condition. Also, in a similar study by Ololade, Alabi, Fadipe and Adegboyega, 2019, it was reported that majority of the respondents demonstrated seeking remedies in at least one or more than one non-medical domains (either with the pastor, imam or traditionalist). In an attempt to cope, some tried to forget about the condition while some others denied the existence of the disease, knowing that it was a possible way of coping with the excruciating effects of the disease. This was reflected in their health-seeking behaviour where many of them engaged in various methods, including orthodox medicine and herbal medicine (Binka, Nyarko, Awusabo-Asare, and Doku, 2018). A larger percentage of the respondents had advanced disease, a correlation that the myths of blame and shame are silencing patients and making early health-seeking behaviour difficult, is buttressed by the shame blame as noted by (Chapple, Ziebland and McPherson, 2004).

‘Evil arrow’ as well as other myths and misconceptions encourages significant delay in medical care-seeking behaviours of cancer patients, particularly presenting to the hospital. Cancer is a disease where myth and misconception can facilitate the delay in seeking appropriate care or rather make patients seek wrong care. The majority of patients have high preference for traditional beliefs and practices that make them visit the herbalists and religious homes while the generality of the participants displayed the understanding of the evil arrow (Ololade, Alabi, Fadipe and Adegboyega, 2019). This was clearly in line with the findings of the study by Kishore et al (2008) who stated that the majority of the people thought that cancer was because of curse, evil eye or as a result of past sin. This elicits that not only in sub-Saharan Africa but also in Asia there could be misconceptions about the cause of cancer. This was also observed by (Akuoko, Armah, Sarpong, Quansah, Amankwaa, Boateng, 2017) who identified the belief of evil spirits as a cause of disease to show a reason for delayed health seeking behaviour of patients. Thus, evil arrow is a pseudonym to infer the effect of metaphysical powers or the evil spirits on the health of the cancer patient.

According to Jegede (2002) in the southwestern parts of Nigeria, the explanation given to various health conditions determine the pathway for seeking help for such conditions. Hence, destiny gives a major explanation for health conditions. Seeking prevention and cure is by patronizing traditional healers thereby seeking medical aid after other options do not work. Therefore, an individual’s perception of the etiology of a disease will lead to a delay in going for orthodox treatment which will in turn lead to late appearance at the hospital. Eventually, when death occurs due to late presentation, people refer to hospitals as ile-iku (houses of death).

Studies by Clegg-Lamptey, Dakubo and Attobra (2009); Osime and Dongo (2002) investigated the neglect of most cancer patients and the side effects of cancer as a typical late-onset pattern for treatment. This reason also explains why some seek optional assistance before going to the clinic. Similarly, in a study of British recognition of health and recovery from illness, Furnham *et al.* (1999) found that the quality of spiritual tenets would generally anticipate fatalistic or health-related convictions. Well-established people were required to point out external causes and remedies for the disease, while those who stocked non-orthodox medicines were required to defend

controllable or internal health, illness and recovery reasons and less likely to have trust in fatalistic or external causes.

In another study conducted by Asuzu *et al.* (2015) on the use of conventional healers by cancer patients in the radiation therapy department of University College Hospital, Ibadan, Nigeria, it was explained that the downturn in patent pharmacies, herbs, and spiritual centres demonstrated that patients have deep convictions that result in contacting varying means when they are faced with the disease. It was also reported that 66% of patients seen at the radiotherapy centre presented at peak stages 3 and 4 and that more than 66% of them had metastatic disease with poor prediction. Late stage presentation and low positive outcome after treatment is the confusing lack of confidence in the western health system for solutions that patients always want, even after falling behind in assessing medical care on time. In this study, the consequence of focus group discussions on cancer patients and conventional healers found that patients attributed their illness to different sources and that the predisposition of elective healers was due to the way in which (i) all cancer cases reported in clinics were reported late (ii) many cases of cancer are based on the beliefs that western health care administrations are not able to relieve them of their ailment, but their trust or beliefs were in the traditional or alternative cure (iii) their care providers manifest a refusal or lack of trust in God with patients and refuse to mention them to individuals who might have the opportunity to give such an expectation or relieve them of their illness.

Reports from a study of 92 patients with rheumatoid arthritis inflammation, patient beliefs about the reasons for their disease, disease outbreaks, disease reduction, and specific disease rate have been shown that the most common causes of the disease were heredity (34.7%), the immune system factor (24.4%), individual practices (22.8%), and mental pressure (22%). 8%). In addition, it was explained that patients who were really looking for the reasons for the disease and who always asked "why me?" reported larger problems and a more noticeable sense of weakness (Affleck, Pfeiffer, Tennen and Fifield, 1987).

In another comparative study analyzing health beliefs in the three British, Ugandan and South African societies, it was discovered that participants from Africa were prone to credit the disease to other malicious people. The participants from Britain

felt that the fatalistic factors were very insignificant, while the two African categories regarded them as an insignificant supporter of the disease (Furnham, Akande and Baguma, 1999). In conventional Yoruba society, Odebiyi (1980) found that individuals attribute diseases and ailments to extraordinary causes while explaining that afflictions and illnesses were often attributed to parents' misdoings especially infirmities that were developed from birth and which the offsprings cannot account for.

In a qualitative study of barriers to cervical cancer screening among Nigerian women (Issa-Modibbo, Dareng, Bamisaye, *et al*., 2016), participants had some misconceptions about the cause of cervical cancer. These varied by religion and geographical location. Among the women in the Focus Group Discussions, a common misconceptions was that cervical cancer could result from wizardry. Participants in this group expressed beliefs about the use of charms and cervical cancer being inflicted on women by men.

Olasoji, Ahmad, Ligali and Yahaya (2011) also explained that half of the participants in a study among the Yoruba ethnic gathering attributed the cause of cancer to the "hands of others". This implies that they have been wounded by powers from another world (obnoxious spirits and hereditary spirits). That the illness was due to curses that mischievous individuals had inflicted on them. They accept that cancer is a path through which tribal spirits communicate their discipline for reprehensible behaviour in families. They understood that cancer was a serious disease-causing persistence and torment. Most of them sought the assistance of the healers before going to the clinic, as the healers were perceived to be more capable of handling extraordinary cases.

2.3.2 Logotherapy (LT) and Blame Attribution (BA) among Cancer Patients

Logotherapy has many applications in the advanced medical and psychological area. A study by Kang, Shim, Kim, Jeong, Song and Sim (2009) sought to assess the impacts of a LT programme for young people with terminal cancer. The study found that LT was capable of improving meaning in and quality of life of young people with terminal cancer. In addition, the study showed that LT can be used as a preventive measure to guarantee young people do not experience existential disorders.

In a systematic review study by Jafari- Koulaee, Khenarinezhad, Abutalebi and Bagheri-Nesami (2018), it was concluded that LT has magnanimous role to play in reducing the level of depression in cancer patients and this could be achieved by tailoring the length and number of sessions to meet the needs of individual patients.

In another experimental study conducted by Mohabbat-Bahar, Golzari, Moradi-Joo and Akbari (2014) to investigate the efficacy of LT towards reducing anxiety among Iranian women with breast cancer, using 30 women diagnosed with breast cancer in two randomized groups and upon completion of group-based counselling sessions, the experimental group showed difference in anxiety levels in the post-test scores. This shows the strength of LT in being able to reduce anxiety in cancer patients.

Southwick, Lowthert and Graber (2016) in a study carried out to determine the relevance and application of LT in enhancing resilience to stress and trauma concluded with relevant evidence that it is capable of assisting people with health and adjustment concerns to be resilient and adjust properly when faced with trauma and adversity. Shahabi (2016) also affirmed that group logo therapy was very potent in improving optimistic life orientation and cancer patients' control of their emotions. Likewise, Ramesh *et al.*, (2014) while trying to ascertain the effect of group LT on the mental health and hope to life of patients suffering from colorectal cancer discovered immense advantage of applying LT due to its potency in reducing distress associated with colorectal cancer as well as increasing hope in the sufferers. Ebrahimi, Bahari and Zare-Bahramabadi (2014) while testing the efficacy of LT concluded that it was capable of increasing hope of patients suffering from leukaemia.

Bhaskaran (2014) examined the norms of LT among more experienced young people who found that their lives were unimportant or who faced difficulties and tried to understand these difficulties. He observed that the feeling of being lost among conflicting demands was especially valid among young people who had not yet built their own sense of identity. These young people intermittently adapted to their companions' values, when these qualities were contrary to their own convictions (Pellebon and Anderson, 1999). In any case, acting outside of their own values, when they are not completely aware of what is the worthy setting, these young people regularly feel in conflict with themselves and occasionally show side effects of

meaninglessness, depression or violence and other problems of emotional well-being. When they have the opportunity to speak and explain their qualities and goals, they increase their self-awareness and sense of identity and cling to a framework of individual values, with the result that their negative emotional states reduced to a minimal level.

A study on post-horrible stress disorder related to combat and alcohol abuse, known for their paralyzing psychosocial work areas, has used LT to reduce the pain of veterans with PTSD. The study found that veterans with demophobia and who were kept out of the war had the opportunity to tell their war stories to multitudes of people after being introduced to LT psychotherapy (Southwick, Gilmartin, McDonough and Morrissey, 2006).

In a meta-survey involving cancer patients, Hamid *et al*. (2011) found, from screening and follow-up assessments of clusters and control that LT was extremely viable in the management of allegations and BA. The lack of progress in average post-test scores and monitoring of control group is evident. The group was not treated. As a result, their distinguished existential emptiness in the underlying valuations continued. The participants in the treatment cohort were then helped to choose the most important option, namely the opportunity to decide their own attitude and their great prosperity. Findings recommend that LT positively affect the levels of distress and the general sense of worthlessness among respondents in the treatment cohort.

In another finding, Blair (2004), encouraged the participants to find and seek meaning with the techniques of LT. The effectiveness of this was recognized by the test group participants who had the opportunity to recognize and salute the outstanding example of their own qualities, this meaning can result from what is provided forever and from what is got out of the world (Frankl, 2006). After helping participants to see the uniqueness of their own qualities, they were urged to focus on the goals, which has integrated them into objectives, defining new objectives for qualities and preparing for the achievement of objectives. The beneficiaries were later assisted to decide functional goals to last in life despite the proximity of challenges.

A comparative study sought to evaluate the efficacy of using LT as an alternative to treatment in alcohol recovery groups. The results showed that gatherings that accepted

LT as a treatment were able to record an increase in life objectives and a reduction in self-destructive ideation and alcohol abuse as opposed to their control counterpart (Crumbaugh and Carr, 1979). Similarly, Somani (2009) reported that organizations and corporate administrators have started to use LT to bring more importance to the workplace. Representatives who were disappointed with the tedious daily work were helped with LT to help them better understand how they include an incentive in their businesses. In this way, corporate supervisors have used important-based treatment to improve profitability and positive thinking in the workplace.

A study by Fillion, Duval, Dumont, Gagnon, Tremblay, Bairati, and Breitbart (2009) that reported the professional satisfaction of maintenance workers in Quebec revealed that medical guards, known for their exceptionally painful and truly demanding work, recorded improvement in job satisfaction and personal satisfaction because of LT which was different from the control. A study by Sadeqee (2009) demonstrated the positive leadership role in reducing grief. Thus, among the victims of catastrophic events, cynical individuals felt more sadness than hopeful individuals. The decline of the disease of depression among people who worry about school is more than hope. There is a huge contrast between idealistic and cynical individuals with regard to the commonality of the side effects of depression. Negativity in people is identified with grief, increased tension, decreased normal progression, and poor physical condition. The positive direction of life is identified with a greater physical and mental change with life's distressing opportunities and a higher level of performance and life satisfaction (Raqibi and Rabani, 2012).

In a quasi-experimental study carried out to investigate the effectiveness of short-term group logotherapy on life expectancy and resilience of women with breast cancer using pre-test and post-test experimental and control groups, the population of 30 women with breast cancer indicated a significant difference between the scores of life expectancy between groups and a significant difference between the mean scores of resilience among groups. It was concluded that group logotherapy is effective in increasing the components of life expectancy and resilience in women with breast cancer, it can help women with breast cancer to find meaning in their life, receive support from groups, adapt themselves with diseases and it can be useful in breast

cancer patient's attitude towards hardships and problems and can increase their strength and resilience (Nader, Ghanbari, Tajabadi pour, Gholipour, Esmaeilzadeh, 2019).

In a quasi-experimental study carried out among 61 breast cancer and gynecological cancer patients (31 in the experimental group and 30 in the control group) to evaluate the effects of logotherapy on distress, depression, and demoralization in breast cancer and gynecological cancer patients, participants in the experimental group who received logotherapy during the intervention showed significant differences in the pre-test and post-test. Logotherapy was effective in the reduction of breast cancer and gynecological cancer patients' depression and demoralization (Sun, Hung, Yao, Fu, *et al*., 2019).

Hajibabaei, Kajbaf, Esmaeili, Harirchian and Montazeri (2020), using a convenience sample of 43 women with multiple sclerosis in a quasi-experimental study comparing the effectiveness of an existential-spiritual psychotherapy with a cognitive-behavioral therapy on quality of life and meaning in life in women with multiple sclerosis, reported that scores for meaning in life improved significantly for existential-spiritual intervention and cognitive-behavioral therapy than those in the control group. Also, the results indicated that women in the existential-spiritual intervention group showed greater improvement in some aspects of meaning in life (search for meaning) and quality of life (role physical and role emotional, pain and energy) compared to women in the cognitive-behavioral intervention group. It was therefore concluded that both existential-spiritual and cognitive-behavioral interventions can improve quality of life and meaning in life among women with multiple sclerosis. However, the findings suggest that although both interventions were effective, the existential-spiritual intervention resulted in more positive improvements in some aspects of meaning in life and quality of life.

Mardanivalendani and Ghafari (2015) examined the effect of logotherapy on quality of life among patients with multiple sclerosis and reported significant differences in the experimental and control groups. Also, among community-dwelling adults with cardiovascular diseases who took part in a 1-month individualized spirituality-based intervention, there was high demonstration of a relatively fair increase in overall quality of life (Delaney, Barrere and Helming, 2011). Similarly, logotherapy was effective in

improvement of quality of life of adolescents with terminal cancer in a study conducted by Kang, Shim, Jeon and Koh (2009) which showed that logotherapy could decrease suffering and increase the meaning in life among adolescents with lethal cancer and can be applied for adolescents to prevent existential pain. Logotherapy can improve the meaning of life and may be effective in relieving the death anxiety caused by recurrent cancer (Tang, Chen and Cheng, 2013). Also, it has been reported that logotherapy can reduce depression and demoralization in patients with breast and gynecological cancers (Sun *et al.,* 2019).

In a study which found out that a reason for reduced Quality of Life in earthquake-affected girls is losing the meaning of life and becoming irresponsible towards it and which used logotherapy to empower the participants to change their attitude, results show that the experimental group recovered in 3 dimensions (physical, psychological, and environmental life), and logotherapy increased their quality of life. As a result, these girls could perceive that although they cannot differ what have happened to them, they can have a better attitude towards the accident which has affected them as well as their life. The clients managed to bring depression and anxiety under their own control and become more adaptable to their living environment. In addition, they released victim and weakness personalities and could communicate more internally (Mehrangiz *et al*., 2012). In another study, group logotherapy was positively effective in reducing the burden of hemodialysis patients' caregivers (Hosseinigolafshani *et al.,* 2020).

Looking at studies conducted by researchers in the country, the impact of LT on the BA of cancer patients has not yet been considered logically. In the same way, this study attempted to seek the impact of LT on BA of cancer patients. The results of the various studies mentioned above demonstrate that LT has a considerable effect on the promising direction of life of cancer patients. It can therefore be said that LT is a useful psychotherapy to change the attitude of cancer patients to life and illness and to trust them to adhere to treatment and cope better.

2.3.3 Cognitive Reframing and Blame Attribution among Cancer Patients

Cognitive Reraming is a common technique which enhances coping and has been utilized among cancer patients. Lepore and Helgeson (2012) perceived CR as a basic advancement that helps men with prostate cancer reinterprete terrible mishaps into reasonable situations and encourage flawed bits of their experience into a fair cognitive state during the period of being bothered. Through sharing after some time, the men with prostate carcinoma started to sort out and structure their treatment experience. The mediation structures of underwriting and solicitation of men's attributions and clarification for their circumstance appear to have invigorated this procedure. In addition, essential reasoning improved after sometime among men who got the therapy.

The findings of Pandey and Vajpeyi (2020) indicated that the pre-test conditions of newly diagnosed cancer patients' coping mechanism, quality of life and life orientation were tremendously improved after being exposed to a 10-week psychological intervention with cognitive therapy and it also led to a reduction in the level of negative feelings. They concluded that along with pharmacological treatments, psychological interventions should also be incorporated in order to improve the mental health of sufferers of cancer especially the newly diagnosed category.

Randomized clinical preliminaries have given solid preliminary support to the efficacy of cognitive intercessions, routinely as a subordinate to treatment in the treatment of a wide degree of illnesses including coronary infection, hypertension, cancer, migraines, unending pain, chronic low back torment, ceaseless inadequacy issue, rheumatoid joint torment, pre-menstrual issue and stomach inadequacies (Beck, 2005). Extra result studies have recorded the accommodating work of cognitive intercessions for patients with different restorative issue in reducing distress and increasing enjoyment and satisfaction (Butler, Chapman, Foreman and Beck, 2006).

Chapman (1997) found the utilization of biofeedback and pelvic muscle practice as a profitable strategy to oversee progress in pelvic floor re-educating in men after radical prostatectomy. This was most clear during the hidden 4 months after wary mediation. After that time, the pace of progress started to level out. The consistency of the exposures depended upon treatment with exercise and biofeedback. The strategy

helped the men produce the exhibition of Kegel practices into their life routine so it could wind up advancing behaviour.

A research has suggested that positive change is usually found among 30-70% of overcomers of different awful occurrences, which include transportation catastrophes (auto crashes, shipping fiascos, plane disasters), disastrous events (tropical storms, seismic tremors), among precious encounters (battle, snare, ambush, kid misuse), restorative issues (cancer, coronary frustration, mind hurt, spinal malady, HIV/AIDS, leukemia, rheumatoid joint distress, sclerosis) and additional valuable encounters (breakdown in relationships, separation of parents, demise of loved ones, immigration), also growth is linked to better socioeconomic status, impelled guidance, primitiveness, charactes like positive thinking and extraversion, cognitive estimations, social support, and issue centered, confirmation, and how to cope with cognitive reinterpretation (Linley and Joseph, 2004).

Helgeson, Reynolds and Tomich (2006) facilitated a meta-intentional audit of 87 research works, suggesting that finding of benefits was identified with low misery and high thriving, yet besides progressively observable genuineness of meddling and avoidant posttraumatic encounters. Proof from the Stanford Internet review following 9/11 (Butler, Blasey, Garlan, *et al.,* 2005) showed that there may be an interaction in the levels of posttraumatic stress and cognitive change, prescribing that there might be a degree of awful experience most pleasing for development.

Schroevers *et al*. (2010) reported that in a sample of over 200 long term survivors of cancer, the more psychological support that was gotten at 3 months following discovery of the ailment, the more recognizable was the experience of cognitive after effects of the infection at 8 years after affirmation, in any event, when controlling for simultaneous degrees of support at that level. Linley, Joseph and Goodfellow (2008) discovered that individuals with evident cognitive change were not predisposed to going through posttraumatic worry at a half year. Frazier, Tashiro, Berman, Steger and Long (2004) referenced that 171 assault survivors complete a survey to quantify cognitive changes at around fourteen days following the trauma, and a brief span later again and following a year. This well-orchestrated study enabled the authorities to perceive how cognitive changes identified with flourishing after some time. Four social undertakings

were made: (1) the individuals who proclaimed low degrees of cognitive change at around fourteen days and raised levels at a year ("extended cognitive change" gathering); (2) the individuals who found gigantic degrees of cognitive change at around fourteen days and low levels at a year ("lost cognitive change" gathering); (3) the individuals who admitted reduced levels twice ("did not experience change in cognition") and (4) the individuals that announced basic levels at both times ("dependably had cognitive change" gathering). Results displayed that those in the "dependably experienced change in cognition" group performed well, indicating the most minimal degrees of misery and posttraumatic stress.

Affleck, Tennen, Croog and Levine (1987) detailed that coronary sufferers that derived gain following their first trauma had decreased incidence of a repeat of the event and death record after about eight years. Epel, McEwen and Ickovics (1998) when looking for biological changes, found that enormous degrees of cognitive change were identified with reduced cortisol levels in ladies acquainted with job worry, as did Cruess, Antoni, Mcgregor, Kilbourn, Boyers, *et al*. (2000) who found lower cortisol levels through the redesign of findings among ladies with breast cancer. Dunigan, Carr and Steel (2007) proclaimed that among patients suffering from hepatoma, those scoring high on cognitive change continued on through 186 days longer than their peers who scored lower, because of higher blood leukocytes. Also, Bower, Kemeny, Taylor and Fahey (1998) found that lower AIDS-related mortality was linked with gains derived by bereaved males as a result of personally admitting receiving satisfaction. Milam (2004) similarly found insusceptibility within HIV patients with reasonable degrees of cognitive change.

In a study carried out to investigate the effects of cognitive reframing and self-acceptance therapies on the enhancement of optimism among students diagnosed with learned helplessness in Ibadan (Ofole and Omole, 2017), results indicated that there was a significant difference among the three groups; cognitive reframing, self-acceptance therapy and the control group. Students with learned helplessness benefitted from the treatment packages more than those in the control group. participants exposed to cognitive reframing therapy had a higher mean score than the group treated with self-

acceptance therapy. Further, cognitive reframing therapy was more potent in enhancing optimism in the participants than the self-acceptance treatment.

In a non randomized study assessing the potency of cognitive reframing (CR) in reducing social disconnectedness among widows, using pre- and post-data collected from a sample of 41 widows in the treatment group and 45 in the control group, results indicated that cognitive reframing is significantly effective in reducing socially disconnected behaviour among the widows in the study. The social disconnected behaviour among the widows reduced by 40.95% compared to 8.29% observed in the waitlist control group when compared with the pre-test scores. The result revealed that there was a significant decrease in social disconnectedness among widows after the intervention (Moses, 2021).

In a study aimed to explore the feasibility and efficacy of a manualized cognitive reframing programme for treating adolescents suffering from post traumatic stress disorder (PTSD), it was reported that after weekly intervention for 12–16 weeks, there were statistically significant improvements in PTSD and depression. Treatment gains were maintained at 3-month follow-up and feedback from referring clinicians also indicated high satisfaction (Rosenberg, Jankowski, Fortuna, Rosenberg and Mueser, 2011). Dublin (2012) compared the effectiveness of cognitive restructuring versus cognitive defusion for claustrophobic anxiety and avoidance. The result shows that participants in the cognitive structuring and cognitive defusion intervention conditions reported a significantly greater reduction in subjective anxiety at post-intervention assessment compared to those in the control group. Other findings reported that CR for social anxiety disorder evidenced a medium to large effect size at immediate post-treatment as compared to control or waitlist treatments, with significant maintenance and even improvement of gains at follow-up (Gil, Carrillo and Meca, 2001).

A study by Peterson and Seligman (2003) had 4817 respondents complete an on-line survey before September 11. By the time scores for people who finished the study in the 2 months following September 11 were put side by side together with the scores for the individuals who finished the study before September 11, seven character attributes indicated appreciation, trust, selflessness, action, love, power, and cooperation. While

the utilization of study self-report is constrained, the possibility of cognitive change when assessed through different procedures shows up substantiated.

Asuzu *et al*. (2015) found the advantages of cognitive reframing in reducing the extent of depression in female cancer patients after a pilot cognitive reframing treatment intervention on female cancer patients was carried out. The participants who were trained with techniques in cognitive reframing recorded a low level of depression when compared with the initial scores before the intervention.

In another study that examined the impact of cognitive restructuring and token economy techniques on the reduction of truancy among secondary school students in Lagos State, Nigeria, findings showed that the two techniques were effective for the reduction of truancy. The significant main effect of treatment confirmed the effectiveness of cognitive restructuring and token economy as appropriate strategies for the reduction of truancy (Sulaiman and Uhuegbu, 2021).

2.3.4 Social Support and Blame Attribution among Cancer Patients

Support from family, friends, and social network members has also been proven to be effective in managing psychosocial issues relating to cancer diagnosis. The supportive role and connectedness of family and friends according to Bentur, Stark, Resnizky, and Symon (2014) in a phenomenological study of Israeli patients with advanced cancer indicated that family connectedness enabled advanced cancer patients to cope with existential and spiritual concerns by providing comfort and support. Also, the supportive roles of participants' significant others in a qualitative study by Majaj, Nassar, and De-Allegri (2013) of the health-seeking behaviours of Palestinian women in the occupied territories confirmed that the study participants' significant others were instrumental in enabling the women to engage in health-seeking behaviors by offering encouragement, support, and assistance.

Findings from Tanjasiri, Mata'alii, Hanneman and Sabado (2011) in a qualitative study of the role of spirituality and worshiping community in coping with breast cancer among Samoans. indicated that spirituality and prayer enabled breast cancer survivors to cope with breast cancer. Spirituality provided considerable emotional strength to them. The church provided financial assistance and social support programs for women with

breast cancer. Findings from Maree and Mulonda (2015) qualitative study of Zambian women with advanced breast cancer indicated that some of the women received support from church while others did not. Findings of Wonders *et al*. (2017) in a qualitative study of the current trends in cancer support within religious communities also indicated that the church provides an ideal atmosphere to support the unique needs of cancer patients.

Womenfolk that reported getting extra support from family, companions, and other parties undergo a more dramatic psychosocial adjustment (Kulik and Kronfeld, 2005) and reduced mental pain which decreases attribution of blame (Gilbar, 2005). In women with advanced cancer of the breast, a higher degree of social support was linked with a better state of mind (Koopman *et al*., 1998). As a result, studies using general proportions of social support have shown that it can assist in protecting women against the mental effects of BA. Further investigation indicates that diverse kinds of social support could help a person in need (Helgeson and Cohen, 1996).

Even more explicitly, scholars have defined three kinds of social support: informational, instrumental, as well as emotional support (Thoits, 2005). Emotional support is made up of a nonverbal and verbal correspondence of thoughts of care as well as interest. The emotional support could aid restoration of self-esteem by indicating that an individual is cherished and esteemed. Additionally, emotionally support can allow beneficiaries to show their emotions, which can result in fewer problems. Also, it can result in to more relational relationships, which may be important for hardous encounters, and maintain a strategic distance between blame and responsibility.

In a study carried out by Pandey and Vajpeyi (2020) to determine the role of therapeutic intervention on the coping patterns of newly diagnosed cancer patients, , it was concluded that having adequate social support is a very important tool needed to manage pain and suffering lack of which has negative consequences on the progression of the disease. Conclusively, they stated that even though cancer is a disease that needs to be properly managed, having family and friends as sources of social support goes a long way in assisting them to cope adequately and positively with issues that may come up as a result of the diagnosis.

In another descriptive study carried out by Muhamad, Afshari and Kazilan (2011), it was inferred that when family members are supportive of cancer survivors in making decisions and in assisting with psychological issues, especially with the spouse being the main pillar of support, assisted by other members of the immediate and extended family, it was easy to cope with the condition and develop other strategies for enhanced quality of life and proper feeding habits.

Support for instruments includes the provision of a guide or substantial assistance, for example assistance in transportation or domestic works. Instrumental support can re-establish the sense of control of the beneficiaries through empowerment with resources that could be employed in exercising power over personal challenging encounters. Pedagogical support includes giving exhortations or facts. The information can create a sense of control in individuals through provision of activities to individuals to assist in adapting effectively in managing their upsetting experience. Cohen and Wills (1985) posited that each of the listed social support could shield individuals from the consequences of disruptions in life.

In light of the classification of social support, various studies that recognize the passionate, instrumental and educational support that cancer patients received was conducted by Helgeson and Cohen (1996). In general, this gives the idea that passionate support demonstrates the strongest connection with coping and adjustment. The link of instrumental support to adjustment is in doubt because it is hardly being evaluated. In addition, enlightening support is seen as useful when the support originates from a competent health care provider. Nevertheless, the linking factor between getting pedagogical support and adjustment cannot be proven. The link among all the aforementioned types of social support and their consequences was examined with reference to breast cancer. Among all the listed types of support and with respect to their link to psychosocial outcomes among women having breast cancer, emotional support received greatest attention. Different proportions of enthusiastic support are identified with positive results among breast cancer patients. Specififcally, women who share their experiences of breast cancer relate successfully with others and experienced better and improved wellbeing (Cordova, Cunningham, Carlson and Andrykowski, 2001).

In addition, women who report having larger amounts of people by whom they could share their concerns on cancer are less afraid of the reoccurence of cancer (Northouse, Templin and Mood, 2001). The inability to reveal these concerns is linked to low psychological wellbeing in the population of the ladies (Figueiredo, Fries and Ingram, 2004). In addition, all the named types of emotional support - reciprocity, affirmation and affect - are linked to healthier family functioning, enhanced marital quality and reduced levels of depression (Primomo, Yates and Woods, 1990). Enthusiastic support is discovered to be associated with longevity in women with cancer of the breast (Reynolds, Hurley, Torres, Jackson, Boyd, *et al*., 2000).

Subjective studies show that women who obtain more obvious measures of physical help are better at utilizing the support at functionting more responsively in their day-to-day activities (Hirschman and Bourjolly, 2005). Instrumental support gotten with spouses presugery was suggested in to predict less distress postsurgery in a longitudinal study of Hispanic women (Alferi, Carver, Antoni, Weiss and Duran, 2001). Also, the level of instrumental support by women obtained lessen the negative link between cancer-related events and discouragement than the enthusiastic support received by the women (Woods and Earp, 1978). Thus, suggesting that accepting a more noteworthy measure of the help provided by others further reduced the link between side effects and disorders than allowing individuals to accept negative cancer concerns.

In addition, when women were simultaneously experiencing innumerable family challenges which are linked to their illness such as changes in family work and making decisions pertaining to the illness; and high levels of help from their accomplice, they had a lower rates of attribution (Primomo *et al*., 1990). Accepting the presence of cancer has a profound effect on patients and on their families. A partner is particularly influenced by fear and vulnerability to treatment, disabled work, the torment and the monetary dangers of treatment expenses, loss of income and finally personal satisfaction. Most importantly, breast cancer reflects the likelihood of a life-threatening condition (Halford, Scott and Smythe, 2000), and research has shown that the mental changes in patients and their accomplices are interdependent (Baider, Koch, Esacson and De-Nour, 1998).

As an observation, the lack of support from an accomplice is associated with attribution complications. As an instance, women having spouses that provide understanding and support say they are better adjusted. On the other hand, the inability of the husbands in offering support throughout the experience of breast cancer leads to women facing more serious problems (Peters-Golden, 1982). Moreover, benefitting from a rewarding association from someone else does not make up for a risky relationship (Pistrang and Barker, 2002).

The suggestion from this is that the relationship of the partner gives an impact on the fact that different connections can neither balance nor be proportionate. Different research works have examined the relationship between outcomes in women with cancer and spousal support. The research works indicate that enthusiastic change and causal attribution to breast cancer is predicted by women's satisfaction with their life partner's response to their passionate needs (Hoskins, Baker, Sherman, Bohlander, Bookbinder, *et al.*, 1996). In addition, being satisfied with the helping relationship between accomplices is related to better mental prosperity (Pistrang and Barker, 2002). Ladies engaged with an accomplice that pays attention to their apprehensions and anxieties and assists at home undergo reduced level of depression in comparism to those ladies that lack such an accomplice (Maly, Umezawa, Leake and Silliman, 2005).

Further, those having breast cancer but experience an increasingly positive passionate contribution from the accomplice are experiencing increased prosperity after a while (Wimberly, Carver, Laurenceau, Harris and Antoni, 2005). The research works show that the support of a life partner is a powerful way to fight against the negative results of breast cancer. Because of the close proximity of partners within a conjugal relationship, women with breast cancer would find spousal social support to be particularly important and essential.

When family members focus on the consideration of giving work at the expense of satisfying other work commitments, this can result in a craze for work and a sense of personal unhappiness (Pearlin and Skaff, 1996). Mui and Morrow-Howell (1993) support this loss of self-esteem through work ingestion. They found that parents and relatives of family members were struggling with work-related difficulties because of lack of support for breakdown and difficulties in their personal and social lives. In addition, because

care commitments limit parents' social contacts and reduce their social jobs outside of work, parents experience a greater loss of self-esteem and discouragement increased. Tension between caregiver jobs and other social jobs can also affect the caregiver-tutor relationship.

Walker, Pratt, and Wood (1993) found that 30% of small girls who taught about their mothers suffering from breast cancer had experienced a conflict between their commitments to care for their mothers and other social jobs. At a time when there was apparently a struggle between their employer and their home chores, the relationships between the care recipients of the parental figure were less favoured. Pearlin and Skaff (1996) found that parenting figures of life partners had greater feelings of unhappiness than adult caretakers, which instead influenced their marital relationships with their breast cancer partners. These results are clarified with regard to the possibility, apart from the job offer, of self-evaluation and remodeling of self-concepts. The amount of connections that we have decreased with age. In addition, care regularly requires a reduction in the time spent participating in these external relationships (Bodnar and Kiecolt-Glaser, 1994). Likewise, those that have higher levels of social support are relatively okay and have reduced mental disturbance (Northouse, 1989). This implies that the change in mental work has generally shown a positive association with social support.

A study by Neuling and Winefield (1998) examining explicit provider support suggests that parental social support is essential. Parents provide more support than companions or others and women regularly trust their accomplices for their illness (Primomo *et al.*, 1990). Additionally, the enthusiastic support of life partner and the family is linked to a darker gloom and a more remarkable marital quality. Enthusiastic and instrumental support of companions is also harmful to problems (Alferi *et al.*, 2001). A quarter of a year after the medical intervention, tensions and depression are identified with satisfaction thanks to the support of parents (Neuling and Winefield, 1998). In addition, less conflict in the family has been reported among more expressiveness women (Spiegel, Bloom, Kraemer and Gottheil, 1983) and a larger family union experience better change with respect to cancer. In addition, when women experienced

countless family stressors identified by their illness and substantial levels of assistance through their accomplices, they had more serious mental difficulties.

Spiegel (1994) found that enthusiastic family support was not equated with social work. In their study, it was felt that passionate family support used a real fictional family stock and that social work was analysed through 20 tasks that assessed daily work-related problems, such as work, accounts, family, work and family companions and private relations. Breast cancer does not only affect women mentally, that is to say the attribution, it also affects in a major way the real life of women.Many researches have studied the link between health outcomes and social support due to its overwhelming impact of cancer on health. Frequently studied health outcome is a general proportion of physical functioning or adjustment. Discoveries are mixed on the link between physical adjustment and social support. For example, women who report more support from their life partners and different adults report less physical impairment than women who are less supportive (Hoskins *et al.*, 1996). Again, Neuling and Winefield (1998) reported that social movement levels were simply negligibly identified with social support. In this study, social support was a summary of the enthusiastic, instrumental and educational support of each of the three providers: family, companions and specialists. The social action was estimated using seven elements proving the state of emotional health in previous studies. The main important link between support and social action was that, in the third month after the medical intervention, women who received more support from their families were gradually participating in social exercises. Neuling and Winefield (1998) found that, despite the fact that one month after the medical intervention, women who received more remarkable support from their companions and specialists had more and more physical problems; A quarter of a year after the medical intervention, the ladies who were gradually satisfied with the support of their companions experienced less physical difficulties. Again, some studies have found no link between social support and physical recovery (Bolger, Foster, Vinokur and Ng, 1996).

Zemore and Shepel (1989) studied the link between social support and BA in cancer patients, defining social support as the ability to discuss emotions and problems with a companion, family member, or sexual partner, life and association with

individuals at work, social and recreational exercises, and association with a more distant family, conjugal work, parental work and family involvement. The authours discovered that women who received more and more passionate support encountered a higher social change and less BA and this is based on previously stated definitions. The main partner is, according to all accounts, fundamentally significant for breast cancer. For example in terms designating the most available member of their household, 90.7% of married women considered their husbands as the most supportive (Neuling and Winefield, 1998), and for the most person considered as confidant, most women with breast cancer favour their spouses (Sandgren, Mullens, Erickson, Romanek and McCaul, 2004). Certainly, when cancer patients get enough social support from everyone, it declines sharply, the rate at which they blame other critics for their condition.

Social support is critical in the treatment of cancer patients. Kelly, Tsilimigras, Hyer and Pawlik (2019) found that caregivers and spouses play an important role by offering guidance and support to patients. They assist the patient to reprocess information related to their treatment decisions. This emphasizes the importance of the supportive role of the spouses who act as caregivers. The study of Van Ryn, Sanders, Kahn *et al.* (2011) also proved that importance of social support by highlighting how majority of caregivers of patients with metastatic disease and severe comorbidity assisted them with activities of daily living, watching for treatment side effects, helping them to manage pain, nausea or fatigue, administering drugs, changing bandages amongst other activities necessary for improved quality of life of the patient.

In another study among young women diagnosed with breast cancer, an increase in social support (measured by amount of social contacts) was associated with increased likelihood of survival (Khalili, Farajzadegan, Mokarian and Bahrami, 2013). In a study carried out to demonstrate the challenges, coping strategies and social support among breast cancer patients in Ghana, findings revealed that women diagnosed with breast cancer in Ghana adopt varied coping strategies to deal with these challenges. The forms of coping strategies adopted by women diagnosed with breast cancer are influenced by the extent of social support received. Hence, it was suggested that psychosocial counselling and support should be an integral part of breast cancer management and

exploring and including social networks could play an important role in the management of breast cancer in Ghana (Benson, Cobbold, Boamah, Akuoko, and Boateng, 2020).

Contrarily, in a study on the fears, barriers and problems in breast cancer diagnosis and treatment, it was found that women with breast cancer face lack of social and emotional support from family and other relationships. Due to the perceived insensitive behavior of people, patients avoid meeting friends and neighbours and they perceive their social body to be inadequate for public sphere. Consequently, breast cancer patients choose to spend more time in isolation as they do not want to face people. Patients prefer social isolation over available social support to avoid negative body image evaluation of their bodies (Saeed, Asim and Sohail, 2021).

2.3.5 Health Self-Efficacy and Blame Attribution among Cancer Patients

Self-efficacy in cancer survival has been characterized by the recognition and resolve of the individual to actively participate in the recovery process, to improve treatment outcomes and advance endurance, health, safety and prosperity. This will include monitoring the results of the disease together with the physical, mental and social treatment getting to know when and how to get help, perceive and detail the signs and side effects of imaginable disease movements and modifying habitual behaviours to advance health, prosperity and longevity (Macmillan, 2010). Individuals are encouraged to practise self-supervision in different ways. However, it is their responsibility to be in touch with health care experts and others to help them.

Failure to give adequate support could have real repercussions; people would become overworked, resulting in less self-management, more significant imbalances, reduced access to government services, even worse health and prosperity. Self-efficacy may reinvigorate cancer patients, increase their certainty of overcoming the problems related to the disease and its treatment and improving their personal satisfaction (Barlow, Bancroft and Turner, 2005). Foster and Fenlon (2011) have put in place a structure for recovering health and prosperity in cancer survivorship that relies on managing self and predisposition towards managing self as key segments. A component of the structure is self-efficacy related to cancer; belief that one can actually perform the required behaviour to create the expected results in case of cancer outcomes and

treatment. Increased self-efficacy is linked to greater effort and diligence to adapt to barriers and increased prosperity. For people with cancer, a high level of self-efficacy is associated with expanded personal care practices and decreased physical and mental cues (Bandura, 1977).

Self-efficacy will probably change depending on the mission to act naturally supervised and likely to change. It has thus become the goal of many self-management mediations. Self-efficacy is certainly not a general characteristic and therefore an individual can not be described as having high self-efficacy or low self-efficacy in all circumstances. Or maybe people have beliefs about their ability to do business and that they will fluctuate according to the specific situation and the idea of the mission. For example, a person may have a strong sense of self-efficacy in the work environment, even if it is low with respect to training. To go further, a person who reports high self-efficacy in the workplace may have very particular beliefs when business-related self-efficacy is analysed in details, for example, high self-efficacy. Therefore, the researcher looked at cancer-related self-efficacy as a whole and then looked at various parts of this part to comprehend the areas in which cancer survivors might have lower self-efficacy to explain the need for mediation.

Various studies on the appropriation of health behaviours have estimated self-efficacy to find out its likely impacts on behaviour change. As individuals continue to think about insurance in general for the purpose of defining a social purpose, thinking about specific action plans, and putting in place a healthy behaviour, they begin to take shape and forge convictions that allow them to change. In a first study, Beck and Lund (1981) presented dental patients with conversation patterned towards changing persons' assumptions about gum disease. Not either the seriousness of the disease or the expected results permitted the presumption of improved behaviour when the belief in self capability was regulated. Belief in self-cability became the chief indicator of the purpose of flossing (r=0.69) and the actual conduct, the recurrence of dental floss (r=0.44). Seydel, Taal, and Wiegman (1990) explained both anticipated and self-efficacy outcomes are encouraging indicators of willingness to participate in practices to recognize breast cancer (using self-evaluation) (Meyerowitz and Chaiken, 1987).

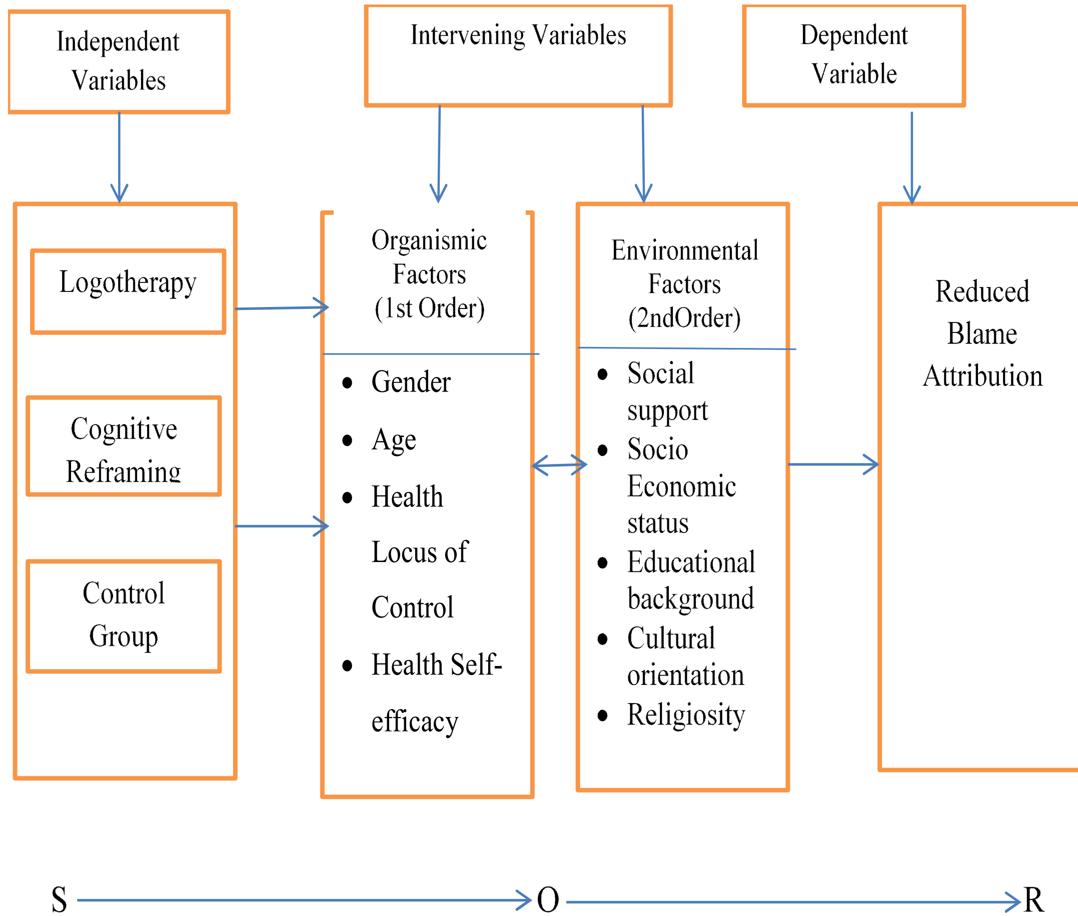
Self-efficacy has been found to anticipate the results of a controlled alcohol consumption programme (Sitharthan and Kavanagh, 1990). It has also been proven to emerge as a tremendous individual asset for adjusting to pressure (Lazarus and Folkman, 1987). Evidence abound to show that apparent self-efficacy in dealing with stressors influences invulnerability (Wiedenfeld, O'Leary, Bandura, Brown, Levine *et al.*, 1990). Subjects with very effective convictions in their capacity are able to adjust better and ready to master the torment compared with those that have less capacity (Altmaier, Russell, Kao, Lehmann and Weinstein, 1993). Self-efficacy appeared to influence circulatory tension, pulse and serum catecholamine levels when adapting to tests or compromising circumstances (Bandura, Cioffi, Taylor and Brouillard, 1988). The recovery of cardiovascular capacity in post-coronary sufferers is also intensified through reliance on physical efficiency and heart efficacy (Taylor, Bandura, Ewart, Miller and DeBusk, 1985). Cognitive-social intervention of sufferers of arthritis has improved their beliefs in efficacy, reduced joint pain and irritation and improvement in well-being (O'Leary, Shoor, Lorig and Holman, 1988). Clearly, it predicts the level of improvement across different parameters (Bandura, 1992).

Desharnais, Bouillon and Godin (1996) also focused on the effectiveness of beliefs about the effectiveness of starting and maintaining a regular exercise program. Weinberg, Gould, Yukelson and Jackson (1981) found that perseverance in physical performance was subject to condemnations of series of tests on being efficient. With regard to targeted execution, a review of the work of beliefs in efficacy in tennis conduct disclosed apparent effectiveness was identified by 12 conduct benchmark criteria that was assessed (Barling and Abel, 1983).

Individuals who were suffering from arthritis and invited to participate in normal physical work-out by improving their apparent efficacy as part of a self-management programme recorded high levels of efficacy after the programme (Holman and Lorig, 1992). In proposing a theory of the effectiveness of concentrated efforts to recover from coronary heart disease, sufferers who had undergone dead myocardial tissue were subjected to a minimal work-out routine (Ewart, 1992). Ewart discovered that trusts about efficiency anticipated under-exercise and overwork throughout a tailored workout. Patients with chronic obstructive pulmonary disease will generally abstain from physical

exertion because of the inconvenience, but rehabilitation require consistency with routine activity (Toshima, Kaplan and Ries, 1992). Consistency with medical regimens was boosted when sufferers of constant obstructive lung disease have undergone cognitive behavioural treatment to enhance the certainty of their abilities. Efficacynbeliefs predicted moderate exercise (r = 0.47), as opposed to control (Kaplan, Atkins and Reinsch, 1984).

Fig. 2.2: The Conceptual Model for Logotherapy and Cognitive Reframing on Blame Attribution among Newly Diagnosed Cancer Patients



Source: The Researcher, 2019

The conceptual framework for this study comprises interventions developed with the aim of managing blame attribution among the newly diagnosd cancer patients. In the conceptual model, the independent variables, Logotherapy and Cognitive reframing are the two interventions used in the study. These independent variables were manipulated by the researcher in order to determine their effects on the dependent variable Blame Attribution. The intervening variables are of two types- the first order intervening variables which consists of the organismic variables that are internally associated with the individuals which include gender, age, health locus of control, health self-efficacy; the second order intervening variables are environmental factors that externally influence the individual which include social support, socio-economic status, educational background,

cultural orientation, religiosity. These variables could produce measurable effects on the dependent variable apart from the independent variables. However, in order to control the effect of the intervening variables on the independent variables, the researcher adopted social support and health self-efficacy as moderating variables. The rationale for adopting these moderating variables is that based on existing literature, social support and health self-efficacy are prominent factors in blame attribution especially among cancer patients. Hence, after exposure to eight weekly sessions of the two therapies (logotherapy and cognitive reframing) , there was an effect on the blame attribution level of the newly diagnosed cancer patients.

CHAPTER THREE

METHODOLOGY

3.1 Design

The study adopted a pretest-posttest, control group, quasi-experimental design with 3x2x2 factorial matrix. In essence, the 3 rows consist of the two interventions Logotherapy, Cognitive reframing and the control group. The rows were crossed with the moderating variables, health self efficacy, varied at two levels (high and low) and social support also varied at two levels (high and low). This is represented in table 3.1.

Table 3.1: A 3x2x2 Factorial Matrix on Blame Attribution among Newly Diagnosed Cancer Patients

Treatments	Health Self-efficacy			
	High		Low	
	Social Support			
	High	Low	High	Low
LT	5	4	5	4
CR	5	5	5	6
CG	5	3	4	3

Key: LT = Logotherapy, CR = Cognitive Reframing, CG = Control Group.

3.2 Population

The population for the study comprised all newly diagnosed cancer patients receiving cancer treatment in cancer centres across southwestern, Nigeria. The justification for the population is that cancer patients in this category are more likely to be having psychosocial issues with regards to their recent cancer diagnosis especially relating to blame attribution. The southwestern Nigeria comprises six states which are Lagos, Oyo, Ondo, Ekiti, Osun and Ogun states.

3.3 Sample and Sampling Technique

The sample size for this study was calculated using the formula for calculating two proportions (Gupta, Attri, Singh, Kaur and Kaur, 2016).

$n = 2(Z\alpha + Z[1-\beta])^2 \times P \times q/d^2$

n = sample size

Zα =alpha value at 0.05 level of significance

$$P = \frac{p_1 + p_2}{2}$$

p_1 – incidence of blame attribution among cancer patients

p_2 – reduction of incidence considered significant

d = effect size

q = 1 – p

Zα =1.96

Zα (1- β) = 0.842 [z values for conventional value of alpha (α) and beta (β) at 0.05 level of significance]

Hence:

$$P = \frac{p_1 + p_2}{2}$$

P_1 = 60% (prevalence level from pilot study)

P_2 =20% (reduction of incidence considered significant)

$$P = \frac{60\% + 20\%}{2} = \frac{80\%}{2} = 40\%$$

q = 1 – p

q = 1 – 40%

= 60%

So:

$n = 2(Z\alpha + Z[1 - \beta])^2 \times P \times q/d^2$

$$n = 2\,(1.96 + 0.842)^2 \times 40 \times \frac{60}{40^2}$$

$n = 2(2.802)^2 \times 40 \times 60/40^2$

$$n = 2(7.851204) \times 40 \times {}^{60}\!/_{40^2}$$

$$n = 15.7024 \times 40 \times {}^{60}\!/_{1600}$$

$$n = \frac{37685.76}{1600}$$

$$n = 23.55$$

which is approximately 24 per group

Bearing in mind the likelihood of attrition among this study population based on the nature of their illness, the following formula was employed to make up for attrition:

N1=n/(1-d)

So:

N1=additional sample size

n=calculated minimum sample size

d= drop out rate set at 10%

Then:

24/(1-10%)=24/0.9=26.66 which is 27 per study group

Therefore, the calculated sample size for this study is 81 newly diagnosed cancer patients. However, due to the sensitive nature of this research, only 63 participants were recruited and engaged in the study at the onset, while 54 of them completed the programme. By implication, the attrition rate was 14.2%; that is nine (9) participants did not complete the treatment.

A multistage sampling procedure was employed in the selection of the participants for this study:

Stage I: Three states (Oyo, Lagos and Ogun) out of the six states in southwestern Nigeria with cancer treatment centres were randomly selected.

Stage II: Purposive sampling technique was used to select only hospitals in each of the three selected states which provide comprehensive cancer care. The hospitals in these states were purposely selected because they are comprehensive providers of cancer treatment in southwestern Nigeria as well as main tertiary referral centers for other hospitals that treat the majority of cancer cases in southwestern Nigeria. These hospitals

include University College Hospital, Ibadan (UCH), Federal Medical Centre, Abeokuta (FMC) and Lagos University Teaching Hospital (LUTH) respectively.

Stage III: Purposive sampling technique was also used to select newly diagnosed cancer patients among other patients for the study. Sixty three (63) newly diagnosed cancer patients that is, University College Hospital, Ibadan (22), Lagos University Teaching Hospital, Lagos (18) and Federal Medical Centre, Abeokuta (23) who scored above the threshold of 45 in the screening instrument (Blame Attribution Questionnaire) were considered to have high rates of blame attribution. This category of patients constituted the participants of the study. However, in each of the selected hospitals, only newly diagnosed cancer patients who met the inclusion criteria were considered eligible to participate in the study. The distribution of participants that completed the treatment and training were 18 patients in LT, 21 patients in CR and 15 patients in the control group who were randomly assigned to the groups through ballot system. The purpose of selecting two intervention groups is because the study is a quasi-experimental study which is aimed at testing the effectiveness of LT and CR among the newly diagnosed cancer patients. 6 male and 48 female participants successfully completed the treatment modules making a total of 54 participants.

3.4 Inclusion Criteria

The following criteria were used in selecting the participants for the study:

i. Newly diagnosed cancer patients registered in the treatment centres and not on admission
ii. Male and female patients who were 18 years and above
iii. Participants who scored above 45 in the screening instrument administered
iv. Cancer patients who were willing to participate in the treatment programme

3.5 Instrumentation `

Four standardized instruments were used to collect data for the study. The instruments were translated back to back to Yoruba language by a language specialist and consultant for consistency with the original meaning and for effective communication between the researcher and some participants who may not understand the English language are as follows:

Blame Attribution Questionnaire

The scale was used as screening tool to assess the participants' rate of blame attribution following cancer diagnosis. The scale was adapted from the Gudjonnson Blame Attribution Inventory-Revised (GBAI-R) developed by Gudjonnson and Singh (1989). The scale measured three sub-scales of blame attribution including mental element attribution, external attribution and guilt feeling attribution. It was modified to 20 items to suit the purpose of the study. The items are rated on a 4-point Likert type scale ranging from 1 (strongly agree) to 4 (strongly disagree). The three major factors representing the three theorised types of attribution emerged each with good test-retest reliability (r = 0.73, 0.85, and 0.78 for mental element attribution, external attribution and guilt feeling attributions, respectively). The scale was considered reliable for use in the study as a Cronbach alpha coefficient of .81 was recorded when it was subjected to pilot testing. Some of the items in the scale include: *"I find somebody to blame for my health condition, I attribute some of my problems to the devil."* Participants who scored above 45 in the instrument were considered to have high rates of blame attribution.

Modified Attributions for Serious Illness Scale

The scale was adapted from the Attributions for Serious Illness Scale originally developed by Mantler, Schellenberg and Page (2003). The scale was used to measure the dependent variable (blame attribution) during the pretest and posttest stages of the study. The items were modified to 25 items to suit the context of the study. The scale measured attribution with sub-scales of controllability, responsibility and blame. It was used to measure patients' attributions for their health condition which include factors such as the extent to which the individuals attribute blame to themselves, the environment, the government, heredity and super natural powers. The items were rated on a 5-point Likert type scale ranging from 1 (strongly agree) to 5 (strongly disagree). The authors recorded good internal reliability alphas greater than .80 (controllability -.91; responsibility -.91 and blame -.82). Validity and reliability of the instrument was sought by pilot testing in similar oncology settings outside the study group to ensure validity and reliability of the instrument. An overall Cronbach alpha coefficient of .85 was reported. Some of the items in the scale include *"This disease is not as a result of my lifestyle, I am not careless about my health, cancer was an attack from evil spirit."*

Health Self-Efficacy Scale (HSES)

This scale was developed by Lee, Hwang, Hawkins and Pingree (2008) and was adopted for use in the study. The Health Self-Efficacy Scale was administered during the pretest stage. The scale measures health self-efficacy using five items, asking participants to indicate their level of agreement on the statements: Examples of items on the scale are "*I am confident I can have a positive effect on my health, I have set some definite goals to improve my health".* All items are scored on a 5-point Likert type scale ranging from 1 (strongly agree) to 5 (strongly disagree). The items in the scale represent a wide range of contexts in which self-efficacy has been measured reliably and they can be adapted to health contexts under study. In a pilot testing conducted to determine the suitability of the scale for the present study, the scale was found to have Cronbach alpha coefficient of .84 which makes it suitable for use in the study.

The Medical Outcomes Survey Social Support Scale (MOSSSS)

Social Support among the cancer patients was measured using the Medical Outcomes Survey Social Support Scale (MOSSSS). It was developed by Sherbourne and Stewart (1991). The Social Support Scale was administered during the pretest stage. The MOSSSS is a brief, multidimensional self-report questionnaire used to assess various functional dimensions of social support (emotional/informational support, tangible support, affectionate support and positive social interaction). The scale was used to measure the moderating variable (social support) enjoyed by the participants in the study. The scale specifically measures behaviours that the spouse, partner and significant others may participate in after a patient's cancer diagnosis, such as willingness to discuss the diagnosis, and how often these people engage in these behaviours. Example of the items on the scale include *"How often is each of the support from someone to give you information to help you understand a situation available to you if you need it"..* After revalidation of the instrument during a pilot testing, the researcher recorded a high reliability coefficient of (α= .89), this is considered adequate and makes the scale suitable for use in the study.

For details of the instruments, see Appendix I.

3.6 Procedure for Data Collection

This study was conducted in accordance with recognized ethical guidelines. The study protocol and proposal were subjected to review by the institutional review boards and ethics committee in each study site. Recommendations made were adhered to by the researcher while payment of approved levies were made before ethical approvals were given for the study to be carried out in each study site. The UI/UCH Ethics Committee assigned number is **UI/EC/18/0534**; LUTH Health Research Committee assigned number is **ADM/DCST/HREC/APP/2637**. At the Federal Medical Centre Abeokuta, the protocol number **FMCA/243/HREC/03/2018/19** was assigned to the study by the Health Research Ethics Committee (See Appendix IV).

The informed consent of the participants was sought due to the sensitive nature of the study and confidentiality issues (See Appendix II). This was translated back to back into the Yoruba language for effective communication (See Appendix III). The selected centres were visited prior to the commencement of the study so as to enable the researcher get acquainted with the participants and the hospital environments. The hospital management were adequately informed of the research through the heads of each unit of the study sites. Preliminary visits were paid by the researcher to the study sites to enhance familiarization of the researcher with the participants and to solicit their cooperation to participate in the study. The participants were addressed and informed as regards the benefits of the research through the assistance of the hospital personnels assigned to the researcher. Two research assistants (one is currently a Ph.D student in the Department of Counselling and Human Development Studies while the other is a student from the Department of Public Health) with vast experience in field and research work were trained and recruited to assist the researcher to facilitate the study.

The study was carried out in four phases: pre-sessional activities, pretest, treatment and posttest . At the pre-session, activities included sensitization of the participants on the importance and benefits of the training and therapies, the recruitment, screening of participants (using the Blame Attribution Questionnaire) and random assignment of the centres into two experimental and control groups. Also, during the familiarization, the researcher and participants agreed on the time as well as convenient venues for the training to take place. With the approval of the supervising hospital

personnels, the participants in the first experimental group agreed to meet in the premises of the Alaanu house UCH, while a segment of the reception area of the oncology units of LUTH and FMC respectively were approved for the researcher and the participants to meet throughout the duration of the study.

At the pretest stage, the questionnaires (Modified Attributions for Serious Illness Scale, Health Self-Efficacy Scale and The Medical Outcomes Survey Social Support Scale) were administered to the participants. The participants in the two experimental groups were exposed to eight weekly sessions of treatment and training, while each session lasted for an average of 60 minutes. The first experimental group (University College Hospital, Ibadan) was treated using Logotherapy while the second experimental group (Federal Medical Centre, Abeokuta) was exposed to Cognitive Reframing therapy. Though the control group (Lagos University Teaching Hospital, Lagos) was given a lecture on "Healthy Diet and Exercise*"*. The posttest instrument was administered following the conclusion of the treatment modules. The treatment modules were translated back to back into the local Yoruba language for effective communication and to cater for participants who did not understand the English language.

The following ethical issues were put into consideration:

Confidentiality of Data: The information obtained from the respondents were kept strictly confidential. Names were not written on the questionnaires such that information provided will not be traced to the participants.

Translation of Protocol: The instrument for data collection and treatment modules were translated back to back to Yoruba language for easy communication between the researcher and the participants that did not understand the English language.

Beneficence: The study was of immense benefit to the participants. It guided them to embrace attitude and behaviours that geared them towards adhering to treatment in order to prevent the disease from progressing to advanced stage. It also served as a foundation for further researches in the area of psycho-oncology.

Non-Maleficence to Participants: This study did not pose any risk or danger to participants. It only took their time for participating in the study.

Voluntariness: The participants were free to withdraw their participation in the study at any time they wished to withdraw.

3.7 Treatment Manuals

The researcher trained the participants on the application of the therapeutic interventions towards the reduction of blame attribution using the following guide:

Experimental Group 1

(LT for Blame Attribution among Cancer Patients)

Treatment Goal: The overall goal of the intervention is to utilise techniques in LT to manage blame attribution among newly diagnosed cancer patients.

Session 1:

Topic: General Introduction, Orientation, Overview and Pre-Test Administration

Objectives: By the end of the session, the researcher was able to:

(i) Build a sound therapeutic alliance with the participants.

(ii) Give the participants orientation about the structure and process of the study and therapy.

(iii) Administer the pre-test instruments to obtain the pre-test scores.

Activities:

Step 1: The researcher warmly welcomed the participants into the programme. She introduced herself and the research assistants. The researcher ensured completion of informed consent forms in order to document their consent to participate in the study.

Step 2: The researcher established rapport between herself and the participants by creating an avenue for researcher/participants' introduction.

Step 3: The researcher provided an overview of the programme. She explained the treatment goals, purpose and the benefits derivable at the end of the programme. The participants were assured of confidentiality during and after the intervention.

Step 4: The participants were informed that the intervention involves eight (8) sessions of one hour each. The researcher and participants then agreed on the day and time for subsequent sessions.

Step 5: The researcher and the participants discussed the rules guiding the conduct of the research. The roles expected of the participants were explained and clarified.

Step 6: The pre-test instruments (Blame Attribution Scale, Social Support Scale and Health Self-Efficacy Scale) were administered to the participants with appropriate guidance from the researcher and the research assistants.

Session Wrap-up:

(i) The researcher gave a brief summary of the session.

(ii) The participants were given homework to read the first part of the book, "Man's Search for Meaning" by Victor Frankl.

(iii) The researcher gave a brief overview of the next session.

(iv) The participants were commended for their cooperation and time.

(v) The researcher appreciated them and encouraged them to attend the next session reminding them of the day, time and venue for the next session.

(vi) The researcher terminated the session.

Session 2:

Topic: Participants' Illness Story, Identity and Meaning.

Objectives: By the end of the session, the participants were able to:

(i) Describe their cancer story.

(ii) Explain their identity before and after cancer diagnosis.

(iii) Have a general understanding of what their authentic sense of identity is and the impact cancer has made on it.

(iv) Appreciate the importance of choosing their attitude and response to life's limitations and challenges.

Activities:

Step 1: The researcher welcomed the participants to the second session of the programme and appreciated them for devoting their time.

Step 2: The researcher reviewed the assignment with the participants. She discussed the central theme of the book 'Man's Search for Meaning' in relation to the

objectives of the research and she asked them to reflect on the themes that they personally discovered while reading the book.

Step 3: The participants were introduced to the topic for the day's discussion and they were encouraged to describe their illness story/cancer experience i.e. their experiences before the diagnosis and how they were eventually diagnosed of cancer. From the initial diagnosis to how they have been affected by it- physically, emotionally and socially. As they tell their stories, the researcher took note of important points for subsequent discussion.

Step 4: The participants were prompted to capture memories of their experiences and moments when they have had fulfilment in life before the diagnosis. They were asked to reflect on their body images, the things they enjoyed doing, people they have had positive encounter with and how the cancer diagnosis had affected them and the things they enjoyed doing previously.

Step 5: The researcher discussed with the participants their identity before and after cancer diagnosis. The participants discussed their traits and the roles they played prior to cancer diagnosis and how these roles had changed after the diagnosis.

The researcher guided them to understand that despite cancer, their traits still remained, they have not lost their identity. They only need to have positive outcomes of cancer experience in order to deeply appreciate what really matters. The researcher assisted the participants to highlight the functions and roles they once performed or fulfilled either as a parent or spouse. These roles may include working to financially support the family, sexual intimacy, playing football or games with a child or grandchild etc. Cancer illness and treatment may seem to make these actions look impossible and may alter one's identity based on these roles but all these can be maintained despite cancer. New methods of being a parent or spouse can be devised. A parent can still watch football and other games with the child or grandchild, share experiences with the child and talk about hopes and dreams for the child even if there is no strength to run around with the child.

Step 6: The researcher explained and placed emphasis on the importance of how one responds to life's limitations and challenges by choosing one's attitude. She discussed how the participants have coped in the past and how they can cope in the future. She assisted the participants to identify how they can make conscious choice to move forward rather than sticking to the previous thought of going through the present situation in a harmful way. The researcher placed emphasis on how their resilience is highly needed and how far their chosen attitude in fighting the illness can go a long way in helping them overcome emotional difficulties associated with the illness. This can be achieved by seeking and adhering to best treatment options rather than sticking to previous beliefs.

The participants were encouraged to demonstrate courage and devote meaningful commitment through the activities they engage in, which will enable them to take responsibility for their treatment and be more determined to face their respective cancer experiences, thereby "turning tragedy into triumph and transforming suffering into a human achievement" (Frankl).

Session Wrap-up:

(i) The participants were asked to reflect on the session theme and how it relates to their experience.

(ii) The participants were reminded to read the book 'Man's Search for Meaning'.

(iii) The researcher asked if there were any comments or questions before concluding the session.

(iv) The researcher wrapped-up the session by thanking the participants for coming and by letting them know that she looked forward to seeing them again during the next session. She reminded them of the day and time for the next session.

Session 3:

Topic: The Concept of Cancer, Risk Factors for Cancer; Meaning of Blame Attribution in Relation to Cancer.

Objectives: By the end of the session, the participants were able to:

(i) Explain the meaning of cancer and the symptoms.

(ii) List some of the risk factors for cancer and ways of preventing it.

(iii) Discuss the issue and problems of blame attribution in cancer.

Activities:

Step 1: The participants were warmly welcomed to the session.

Step 2: The researcher asked the participants their previous knowledge about cancer, the risk factors and symptoms of various types of cancer.

Step 3: The researcher built on the knowledge of the participants about cancer. She discussed the meaning of cancer.

Cancer diseases are characterized by excessive, accelerated, deregulated, uncontrolled growth, division and spread of abnormal cells which may invade and destroy other tissues in the body. Whether due to hereditary or environmental causes, cancer involves a malfunction of genes that control cell growth and division. The uncontrolled spread of abnormal cells or metastasis can affect the functioning of other organs. The common feature of all types of cancer is the uncontrollable growth and accumulation of abnormal cells. Normal cells behave according to a genetically predetermined set of rules unique to the particular cell type (skin, blood, brain). These normal cells divide, mature, die, and are replaced systematically. Cancer cell growth differs from normal cell growth. Due to damaged DNA, instead of dying, cancer cells continue to grow and form abnormal cells that grow more rapidly, in a disorderly fashion and they do not mature correctly. These cells can grow into malignant tumours that replace normal surrounding tissue and spread throughout the body. (Nezu, Greenberg and Nezu, 2010). Cancers can arise in many parts of the body leading to a range of cancer types and in some cases spread to other parts of the body through the blood and lymph systems (IHME, GBD, 2016).

Risk factors for cancer were listed and explained (risk factors are those factors that can predispose an individual to have a disease).

Several risk factors have been identified for cancer such as tobacco smoking and environmental chemicals, in addition to the carcinogenic role of certain viruses, occupational association of cancer, its relationship with cerain hormones and dietary habits and the genetic basis of cancer (Azizi, Bahadori, and Azizi, 2013).

The symptoms of various types of cancer were listed and discussed. All these are expected to disabuse the minds of the participants from their long held beliefs and attribution.

Step 4: The researcher discussed steps that can be taken to prevent cancer viz a viz steps that can be taken to ensure early detection in order to benefit from treatment or manage the condition better.

These tips are useful for participants who want to help create awareness about cancer and those that aim to be advocates of cancer prevention and treatment.

Step 5: The researcher explained to the participants that cancer cannot be transmitted through any of the following ways:

-casual contact with a cancer patient e.g. through hugging, sitting close, sharing utensils, dancing together.

-sharing same shower/bathroom/toilet/sleeping on same bed with a cancer patient.

- insect bites.

Step 6: The concept of blame attribution was discussed with the participants.

Blame attribution is the process of inferring the causes of events or behaviour to one self, the environment or to significant others. In life, we attribute blame almost everyday either consciously or unconsciously. Human beings are more likely to blame other people for events or conditions that are not favourable to them. For example, when a student gets a poor grade in a course, he/she is more likely to blame the teacher for not possessing good teaching skills or for not explaining a concept well not taking into cognizance, the fact that he/she may not have studied well. In another vein, he/she may attribute a good grade earned by another classmate to luck, not wanting to admit that he/she may have excellent study habits.

The attributions made by people everyday have important influence on their feelings and thinking which in turn affects the action taken by such individuals.

Blame attribution among cancer patients manifests when patients attribute the cause of their illness to themselves based on what they had done previously, the environment or significant others around them. Some people attribute the disease to supernatural powers or even evil spirits.

Step 7: The researcher explained to the participants that since the risk factors for cancer have been identified, it is not safe for patients to attribute the causes of their health condition to other factors that are not evidence based.

Session Wrap-up:

(i) The participants were given opportunity to ask questions.

(ii) The participants were asked to explain the concept of cancer, the risk factors and signs and symptoms of cancer.

(iii) The researcher summarised all that has been discussed on the concept of cancer, the risk factors and symptoms of cancer as well as blame attribution among cancer patients.

(iv) The researcher appreciated and commended the participants for their cooperation.

(v) The participants were reminded of the day and time for the next session.

Session 4:

Topic: Meaning of LT, Processes and Techniques of LT in Relation to Blame Attribution among Cancer Patients.

Objectives: By the end of the session, the participants were able to:

(i) Demonstrate an understanding of the term LT.

(ii) Apply the processes of LT to the reduction of blame attribution.

(iii) Identify the techniques of LT and apply them whenever the need arises.

Activities:

Step 1: The researcher welcomed the participants warmly and checked how they were doing.

Step 2: The researcher reviewed the book 'Man's Search for Meaning' with the participants. The participants were asked to summarise the book and the researcher discussed the content of the book and linked it to the present intervention being applied to the participants.

Step 3: The researcher explained the term LT and discussed with the participants.

LT simply means therapy through meaning. It is a therapy that helps people to reduce despair in severe circumstances by incorporating personal meaning through attitudes, experiences, and behaviours. It is a therapy designed to help diminish feelings of despair that can be associated with cancer by helping patients focus on the importance of creating, reconnecting with, experiencing, and sustaining meaning in the face of illness. It helps individuals to make appropriate choices in the future.

LT is a spiritually oriented approach towards psychotherapy that capitalises on the characteristic of human beings as meaning-seeking and meaning-making beings.

LT is of the proposition that the human spirit is our healthy core and it may be conceptualised as our basic yearning and capacity for meaning and spirituality. It is premised on the fact that people can be pushed to understand a "will to meaning," ie an internal drive towards achieving meaning in life. Similarly, Frankl was of the opinion that, "inherent in our responses to life lies the growth and freedom to choose". The three basic tenets of LT which are freedom of will, will to meaning and meaning of life are essential for living a meaningful life.

Freedom of Will emphasises the human capacity for self-determination and choosing the right attitude even in the most undesirable or restrictive circumstances.

Will to Meaning refers to the primary intrinsic motivation of seeking meaning and living a meaningful life even when the condition is not favourable or even for terminally ill patients. This is important for resilience and wellbeing. Will to meaning can be best understood as the will to live inspite of pain or suffering.

Meaning of life can be discovered up till an individual takes his/her last breath. Getting the meaning of life is a primary motivation for living. Once an individual discovers the

motivation for living, he/she strives to fulfill the requirements for continuous living. The meaning of life can be discovered by activities in the world through interaction with others.

In the case of cancer, the individual strives to meet up with treatment procedures and drops the idea of attributing blame. LT is of the proposition that if man can find and fulfill meaning in his life, he becomes happy and capable of coping with suffering. Through the three values of discovering meaning (creative, experiential and attitudinal) in LT, cancer patients are capable of taking a heroic stand and transforming suffering into the highest form of human achievement. Life becomes meaningful to the extent that suffering holds positive meanings.

Step 4: The researcher discussed the processes of LT in relation to blame attribution among cancer patients.

LT is a psychological therapeutic treatment comprising a spiritual approach to the root of a problem which helps people appreciate their responsibility for existence, gain liberty out of emotional distress and find the meaning and purpose of their life. The propounder of LT, Frankl, narrated a case in which a terminally ill cancer patient lost the desire to live and ended up suffering from pain due to loss of hope but when he eventually succeeded in finding meaning in life, he was boldly able to accept the condition. He then strived to cope with the requirements that enabled him to face treatment. He concluded that pain should not be a torment to patients if they could determine the meaning of their pain as important resources and powerful predictors for coping with emotional suffering.

The researcher explained to the participants that man's ultimate freedom is the ability to choose how to respond to any set of given circumstances, even painful ones.

Step 5: The researcher discussed the techniques of LT with the participants and taught them how to apply them.

Dereflection: When people focus on the possibility of a problem or a symptom with such intensity that they create anticipatory anxiety that actually makes the problem or symptom worse, dereflection is used to change an individuals's orientation from the preoccupying problem or sign then, refocus the attention instead onto related, highly motivating areas of personal life meaning. The resulting effect is typically a reduction of

the anticipatory anxiety associated with the symptom or problem in question and thus a reduction in the symptom or problem itself.

This process is in contrast to hyperreflection which involves paying too much attention to or focusing too much on a situation thereby creating an unconscious move to self-observation. It changes the attention to another person or a meaningful activity and moves it away from the observed signs (Frankl, 2004). Lukas (1998) describes the procedure as a two-step process: one—a “stop signal” is given to the client, to ignore the ruminative thoughts. The second step is a “deviation signal” designed to change the direction of one’s outward thoughts and focus on meaning. Complete absorption in a meaningful task makes us forget about ourselves, be creative and be interested in fulfilling values. The participants were asked to shift their focus from a seemingly intractable problem to something bigger and positive and they were made to understand that too much focus should not be placed on symptoms to the detriment of their strengths.

Paradoxical intention: This technique was initially used by Frankl in the 1920s. It applies self-distancing by using humour or, at times, absurdity. For example, a client may be directed to imagine himself being in the condition of the dreaded fear by wishing for (with humour) the very object that leads to the dreaded anxiety. For instance, when an individual goes through paniic attacks and constantly dreads having a heart attack, he would be instructed to say to him/herself: “I look forward to having a dandy of a heart attack today, falling to the ground and making a spectacle of myself.” Paradoxical intention counteracts anticipatory anxiety by having a reciprocal impact on the symptoms and thus breaking anxiety’s vicious circle. LT posits the use of humour as the main crust of this technique and what makes it different from techniques of behaviour modification (Frankl, 2004). Humour is a good approach used for the sign not against the individual. In summary, paradoxical intention begins with self-distancing from one’s symptom (through humour), This is succeeded with a symptom reduction and a change of attitude in the individual. In the application of paradoxical intention, we create humour and actually laugh about the thing we fear most thereby releasing ourselves from anxiety and feeling of helplessness.

The participants were encouraged to imagine a worst-case scenario that is so ridiculous and so impossible that the only logical response was to laugh at it. This technique will help them in self-distancing or self-detachment. By distancing oneself from the problem, one gains some clarity and perspective so that the problem no longer defines or consumes the individual. In self-detachment, while one may not be totally free from the health condition, one is free to choose the attitude to be taken towards the condition and actions can be taken towards making changes.

Modification of Attitude: This focuses on modifying one's attitude, as opposed to modifying one's thoughts or behaviours. The participants are encouraged to adopt a new attitude towards the present problem in order to process their situation better.

Socratic Dialogue: This is an empowering technique which enables clients to discover the resources that they have within themselves which can be used to overcome their problems. This process allows a person to realize that the answer lies within and is just waiting to be discovered.

The researcher listened intently to the participants' harmful thoughts, pointed out specific patterns of words, or word solutions to the participants. She guided them to see new meaning in them and led them to realise alternative ways of thinking. This was to change the harmful thoughts and help them develop different ways of thinking.

Step 6: The researcher discussed with the participants, how these techniques could be applied to real life situations.

Session Wrap-up:

(i) The participants were given opportunity to ask questions.

(ii) The participants were asked to describe LT, its processes and techniques and how they can be applied to their present condition.

(iii) The researcher summarised the activities of the session and commended the partricipants for their time and effort.

(iv) The day and time for the next session was emphasized.

Session 5:

Topic: The Basic Tenets of LT in Relation to Blame Attribution.

Objectives: By the end of the session, the participants were able to:

(i) Demonstrate an understanding of the tenets of LT and apply them to the management of blame attribution.

Activities:

Step 1: The participants were warmly welcomed to the session.

Step 2: The participants were prompted to summarise the activities of the previous session with appropriate guidance from the researcher.

Step 3: The researcher explained the basic tenets of LT to the participants.

LT is built on three basic tenets which are interconnected. This is because human beings have the intrinsic motivation for meaning and they are free to choose and live a meaningful life because meaning can be found/discovered in all circumstances.

1. **Freedom of Will:** Individuals need to develop the capacity for freedom of will in order to be able to choose how to respond to a given situation and decide on a preferred life path. This enables human beings to be responsible, moral agents who cannot escape from making choices or being accountable for the consequences of their decisions and actions. Freedom of will means freedom to find meaning in existence and to choose one's attitude towards suffering and to choose how to respond to uncertainty. Frankl suggested that "the last ultimate vestige of freedom that we have as human beings is to consider and choose our attitude towards suffering, even when almost every other freedom has been taken from us". Cancer illness and treatment create significant limitations, suffering and relinquishing of a great deal of control but despite these limitations imposed by cancer, one does have the freedom to choose how one responds and the attitude one takes to the cancer experience.

The researcher explained to the participants that in order to overcome blame attribution, they need to develop the capacity of freedom of will in order to gain the responsibility of personal response viz a viz the way they respond to their present condition and the meaning they give to their condition and how they interprete it. She emphasises that individuals are responsible to themselves, to other people and to the society and that

individuals are free to choose whatever they want in order to achieve success, happiness and good health.

2. **Will to Meaning:** The will to meaning is essential for survival and health. It is the primary motivation of seeking meaning and living a peaceful life. Human beings should not be pushed by drives, instincts and past histories of reinforcement but should be drawn forward by the need to fulfill future meanings in order to gain value in life. The desire to find meaning in human existence is a basic primary motivating force shaping human behaviour.

The researcher explained to the participants that the will to meaning is best understood as the will to live. In order to overcome blame attribution and the negative emotions that come with it, participants need to develop a strong will to meaning which enables them to endure unimaginable sufferings and to persist in pursuing steps that would lead to attaining better adjustment in cancer.

3. **Meaning of Life:** Life has meaning and never ceases to have meaning. This possibility of experiencing or creating meaning exists until the last moments of one's life. Meaning of life affirms that meaning can be found even in the most miserable and tragic circumstances. Life has meaning in one's existence as a whole not only in specific situations.

The researcher explained that it is not the meaning of life in general that matters but the specific meaning of a person's life at a given moment. This is because each person needs to discover the meaning of the present situation for himself.

The participants were guided to potential areas of discovering meaning through:

- One's reflection on life experiences.
- Active engagement in the world and with people.

The researcher guided the participants to discover that detecting meaning in situations like cancer is essential to meaningful living using Nietzche's saying: "He who has a why to live for can bear with almost anyhow". This means that when individuals are stripped of everything that makes life worth living for or when they are battling with a disease like cancer or when they are in pain or despair or when they are confronted with a hopeless situation, meaning makes suffering more bearable and provides an individual with more reasons for living in order to overcome such situations.

Step 4: The participants were asked to list steps they intend to take in order to overcome blame attribution using the tenets of LT.

Session Wrap-up:

(i) Questions were entertained from the participants.

(ii) The participants were asked to itemise the tenets of LT and explain how they can be used to overcome blame attribution and its consequences.

(iii) The researcher wrapped-up the session and commended the participants for their attention.

(iv) The participants were reminded of the day and time for the next session.

Session 6:

Topic: Sources of Meaning and Blame Attribution

Objectives: By the end of the session, the participants were able to:

(i) Identify sources of meaning and apply these sources to the management of blame attribution.

Activities:

Step 1: The researcher welcomed the participants and revised the activities of the previous session with them.

Step 2: The participants were prompted to explain situations that led to attributing the causes of the present situation/health condition to external causes rather than medical or empirically tested factors.

Step 3: The researcher explained that no matter the condition we face in life, our attitude can always help us. We are not moved by events but by our interpretation of the events. Even in cancer, we can show courage and turn the present situation into a meaningful one.

Step 4: The researcher enlarged the participants' discernment of meaning-in the past, present and future creatively, experientially and attitudinally.

Meaning through Creative Values: The researcher broadened the participants' view of the spectrum of meaning and values which is meaning through the value that we create,

achieve and accomplish. This includes things we can offer to humanity like creating a duty, achieving a task or performing deeds that are counted as being worthy.

Meaning through Experiential Values: The experiential value is what we take from the world, such as the experience of truth, beauty and love towards another human being.

Meaning through Attitudinal Values: This shows our attitude in situations that cannot be changed or in sufferings that are not avoidable.

Individuals have the freedom to find meaning through meaningful attitudes even in apparently meaningless situations. An example of this is illustrated when Frankl, the propounder of LT helped a patient who could not overcome the emptiness he felt as a result of the loss of his wife to do so. He wanted to know what would have happened if the man had died before his wife and she would have had to survive him. The man responded by saying it would have been terrible for her and she would have suffered. Frankl assisted him to find a meaning to his present situation by explaining to him that his wife had been spared the suffering by her husband and he had to pay for it by surviving her and mourning her.

Session Wrap-up:

(i) The participants were permitted to seek clarifications on grey areas.

(ii) The participants were required to explain how they can derive meaning through creative, experiential and attitudinal values.

(iii) The researcher summarised the activities of the session and commended the participants for their attention and cooperation. She also reminded them of the time and venue for the next session.

Session 7:

Topic: Self-Instruction and Motivation in Relation to Blame Attribution

Objectives: By the end of the session, the participants were able to:

(i) Identify the importance of self-instruction and motivation and apply them.

(ii) Become more confident in themselves by instructing themselves with more positive attitudes and statements e.g “I can survive this”.

(iii) Develop new attitudes about cancer, plans and purposes for present and future life.

Activities:

Step 1: The researcher commended the participants for their devotion to the study while welcoming them warmly.

Step 2: The researcher reviewed the activities of the previous session with the participants.

Step 3: The researcher explained the meaning of self-instruction and its importance.

Self–instruction involves the use of self-statements to regulate or direct behaviour.

The participants were guided to use the following guidelines to overcome blame attribution.

1. **Problem Identification:** The problem (cancer) has been identified along with its causes (risk factors).
2. **Planning:** Treatment plan and understanding all it entails.
3. **Coping** and Dealing with the difficulties that may be encountered.

Step 4: The researcher explained that when the participants do away with the beliefs about the causes of their health condition, they will be more motivated to carry on with their treatment.

Session Wrap-up:

(i) The participants were charged to equip themselves with self-instructional statements and become more motivated to combat cancer by adhering to the treatment and not dwell on attribution.

(ii) The participants were commended for their attention, participation and cooperation.

Session 8:

Topic: Overall Review, Post-test Administration and Conclusion

Objectives: By the end of the session, the participants were able to:

(i) Summarise the skills they have acquired since the commencement of the intervention and how it has helped in managing blame attribution.

(ii) Respond to the post-test instrument.

Activities:

Step 1: The participants were warmly welcomed and they were commended for making it to the end of the programme.

Step 2: The researcher established an interactive session with the participants to ascertain the effect of the intervention.

She used the following questions to bring about reflection and feedback:

(i) What has it been like for you to go through this learning experience over the last eight weeks?

(ii) Have there been any changes in the way you view your life and cancer experience after having been through this process?

(iii) Do you feel like you have a better understanding of the condition and you will be able to use the knowledge gained to better manage the illness?

(iv) What are your hopes for the future?

Step 3: Activities of the previous sessions were role-played to ensure full grasp of the intervention.

Step 4: The post-test instrument was administered.

Step 5: The researcher thanked the participants for their cooperation throughout the programme and for participating in the study.

Session Wrap-up:

(i) The participants were encouraged to express any final thoughts or comments they have to share.

(ii) The participants were encouraged to fully utilise the skills they have acquired during the intervention programme.

(iii) The participants were encouraged to always remember the following quotes:

- “He who has a WHY to live for can bear with almost ANYHOW” (Nietzsche)
- “We can’t be in control of which way the wind will blow but we can be in control of what we do with the wind in our sails”
- The freedom to choose one’s attitude in any given set of situations cannot be taken from man even if everything is taken away from him …”(Frankl).

(iv) The researcher brought the study to an end by thanking the participants for being a meaningful part of the therapeutic encounter. She also acknowledged the honour and privilege of sharing in the participants’ stories.

Experimental Group 2

(CR Psychotherapy For Blame Attribution Among Cancer Patients)

Treatment Goal: The overall goal of the treatment is to help increase the capacity of cancer patients in managing blame attribution as well as emotional problems attached to it through CR.

Session 1:

Topic: General Introduction, Orientation, Overview and Pre-Test Administration

Objectives: By the end of the session, the researcher was able to:

(i) Build a sound therapeutic alliance with the participants.

(ii) Give the participants orientation about the structure and process of the study and therapy.

(iii) Administer the pre-test instruments to obtain the pre-test scores.

Activities:

Step 1: The researcher warmly welcomed the participants into the programme. She introduced herself and the research assistants.

Step 2: The researcher established rapport between herself and the participants by creating an avenue for researcher/participants’ introduction. The researcher ensured completion of informed consent forms in order to document their consent to participate in the study.

Step 3: The researcher provided an overview of the programme. She explained the treatment goals, purpose and the benefits derivable at the end of the programme. The participants were assured of confidentiality during and after the intervention.

The participants were assured that the programme would create in them new thinking processes that would improve their health status. The importance of regular attendance was emphasized as it would ensure full benefits by the participants.

Step 4: The participants were informed that the intervention involved eight (8) sessions of one hour each. The researcher and participants then agreed on the day and time for subsequent sessions.

Step 5: The researcher and the participants discussed the rules guiding the conduct of the research. The roles expected of the participants were explained and clarified.

Step 6: The pre-test instruments (Blame Attribution Scale, Social Support Scale and Health Self Efficacy Scale) were administered to the participants with appropriate guidance from the researcher and the research assistants.

Session Wrap-up:

(i) The researcher gave a brief summary of the session.

(ii) The researcher gave a brief overview of the next session.

(iii) The participants were commended for their cooperation and time.

(iv) The researcher commended them and encouraged them to attend the next session while reminding them of the day, time and venue for the next session,

(v) The researcher terminated the session.

Session 2:

Topic: The Concept of Cancer, Risk Factors for Cancer; Meaning of Blame Attribution in Relation to Cancer.

Objectives: By the end of the session, the participants were able to:

(iv) Explain the meaning of cancer and the symptoms.

(v) List some of the risk factors for cancer and ways of preventing it.

(vi) Discuss the concept and problems of blame attribution in cancer.

Activities:

Step 1: The participants were warmly welcomed to the session.

Step 2: The researcher asked the participants to explain their previous knowledge about cancer, the risk factors and symptoms of various types of cancer.

Step 3: The researcher built on the knowledge of the participants about cancer to discuss the meaning of cancer.

Cancer diseases are characterized by excessive, accelerated, deregulated, uncontrolled growth, division and spread of abnormal cells which may invade and destroy other tissues in the body. Whether due to hereditary or environmental causes, cancer involves a malfunction of genes that control cell growth and division. The uncontrolled spread of abnormal cells or metastasis can affect the functioning of other organs. The common feature of all types of cancer is the uncontrollable growth and accumulation of abnormal cells. Normal cells behave according to a genetically predetermined set of rules unique to the particular cell type (skin, blood, brain). These normal cells divide, mature, die, and are replaced systematically. Cancer cell growth differs from normal cell growth. Due to damaged DNA, instead of dying, cancer cells continue to grow and form abnormal cells that grow more rapidly, in a disorderly fashion and they do not mature correctly. These cells can grow into malignant tumours that replace normal surrounding tissue and spread throughout the body. (Nezu, Greenberg and Nezu, 2010). Cancers can arise in many parts of the body leading to a range of cancer types and in some cases spread to other parts of the body through the blood and lymph systems (IHME, GBD, 2016).

Risk factors for cancer were listed and explained (risk factors are those factors that can predispose an individual to have a disease).

Several risk factors have been identified for cancer such as tobacco smoking and environmental chemicals, in addition to the carcinogenic role of certain viruses, occupational association of cancer, its relationship with cerain hormones and dietary habits and the genetic basis of cancer (Azizi, Bahadori, and Azizi, 2013).

The symptoms of various types of cancer were listed and discussed.

All these are expected to disabuse the minds of the participants from their long held beliefs and attribution.

Step 4: The researcher discussed steps that can be taken to prevent cancer viz a viz steps that can be taken to ensure early detection in order to benefit from treatment or manage the condition better. These tips are useful for participants who want to be help create awareness about cancer and aim to be advocates of cancer prevention and treatment.

Step 5: The researcher explained to the participants that cancer cannot be transmitted through any of the following ways:

- casual contact with a cancer patient e.g. through hugging, sitting close, sharing utensils, dancing together.
- sharing same shower/bathroom/toilet/sleeping on same bed with a cancer patient.
- insect bites.

Step 6: The concept of blame attribution was discussed with the participants.

Blame attribution is the process of inferring the causes of events or behaviour to one self, the environment or to significant others. In life, we attribute blame almost everyday either consciously or unconsciously. Human beings are more likely to blame other people for events or conditions that are not favourable to them. For example, when a student gets a poor grade in a course, he/she is more likely to blame the teacher for not possessing good teaching skills or for not explaining a concept well not taking into cognizance, the fact that he/she may not have studied well. In another vein, he/she may attribute a good grade earned by another classmate to luck, not wanting to admit that he/she may have excellent study habits.

The attributions made by people everyday have important influence on their feelings and thinking which in turn affects the action taken by such individuals.

Blame attribution among cancer patients manifests when patients attribute the cause of their illness to themselves based on what they had done previously, the environment or significant others around them. Some people attribute the disease to supernatural powers or even evil spirits.

Step 7: The researcher explained to the participants that since the risk factors for cancer have been identified, it is not safe for patients to attribute the causes of their health condition to other factors that are not evidence based.

Session Wrap-up:

(vi) The participants were given opportunity to ask questions.

(vii) The participants were asked to explain the concept of cancer, the risk factors, signs and symptoms of cancer.

(viii) The researcher summarised all that have been discussed on the concept of cancer, the risk factors and symptoms of cancer as well as blame attribution among cancer patients.

(ix) The researcher commended the participants for their cooperation.

(x) The participants were reminded of the day and time for the next session.

Session 3:

Topic: Meaning of CR, processes and techniques of CR in relation to Blame Attribution among Cancer Patients

Objectives: By the end of the session, the participants were able to:

(i) Explain the term CR

(ii) Identify the process of CR in relation to Blame Attribution among Cancer Patients.

(iii) Identify and apply the techniques of CR to their present health condition

Activities:

Step 1: The participants were introduced to CR.

CR is a psychological technique that attempts to help people stop having negative or stressful thoughts. CR psychotherapy focuses on problem resolution rather than identification.

When something difficult or stressful happens to us, the way we react to the situation and the thoughts we have about the situation are extremely important-more important than the situation itself.

Negative thoughts are dysfunctional and lead to thinking distortions.

These lead to distorted beliefs and they may affect our behaviour.

Step 2: The researcher gave practical examples of irrational thoughts.

Negative beliefs could be changed through reframing our thoughts.

For example, after being diagnosed of cancer, an individual may begin to have thoughts like:

" I am so unlucky"

" I am never going to be able to live long in life"

" I will never forgive whoever is responsible for my predicaments"

Instead of dwelling on thoughts like these, one should reframe those thoughts to positive in response to the situation, preparing for how best to deal with the cancer diagnosis and how to do better with regards to the treatment by seeking and adhering to orthodox treatment.

Step 3: The researcher trained the participants on the importance of managing negative thoughts before they lead to negative behaviour.

The participants were trained on how to dispute negative thoughts.

E.g. 1. "Is there any evidence that these negative beliefs are true?"

2. "Does dwelling on these thoughts bring about more good or harm?"

3. "Do the beliefs provide any answer to our problems?"

4. "Is there anything helpful about dwelling on these beliefs?"

5. "Are the beliefs logical?"

6. "Is there any evidence for holding on to these beliefs?"

When individuals are able to answer these questions objectively, they might be able to dispel negative thoughts.

Step 4: The participants were asked to mention some irrational thoughts they have had about cancer and together with the researcher, they attempted to dispute those irrational thoughts.

Session Wrap-up: (i) The participants were encouraged to seek clarifications.

(ii)The researcher gave a brief summary of the session and commended the participants for their cooperation

Session 4:

Topic: Techniques of CR Psychotherapy in relation to Blame Attribution in Cancer Patients.

Objectives: By the end of the session, the participants were able to:

(i) Generate solutions to negative thoughts they may have had about cancer thereby living more satisfied lives.

Activities:

Step 1: The participants were received warmly while the researcher reviewed the activities of the previous session with them.

Step 2: The participants were trained on how to identify, challenge and alter stress-inducing thought patterns and beliefs replacing them with more accurate and less stress - inducing thinking habits.

Unhelpful thinking in the form of dysfunctional beliefs or cognitive distortions is like a bad habit that creates emotional problem for individuals. With practice and effort, people can become more aware of what is happening in their minds and change how they think for the better.

Step 3: The importance and techniques of CR were explained to the participants. CR is a very powerful therapy that has been used to help people cope with all manners of stressful events and conditions.

CR teaches us to stop trusting in our automatic tendency to accept the contents of our thoughts as being an accurate assessment of reality.

There is the need to test each thought that comes to our mind for accuracy.

The equation is as follows:

A - Activating event

B – Belief

C – Consequences of our thoughts

D – Disputing/ Debating the thoughts

E – Effective replacement of thoughts

To reframe our thoughts we:

- examine the content of the thoughts and the emotional consequences of the thoughts. Then, we think carefully about whether our thoughts may have been wrong.
- When it is clear that we are wrong, or we are clear on whatever we got wrong, we rephrase or restate our thought patterns in more accurate and less distorted format.

The effective techniques of CR are:

(i) To monitor and record AB and C especially by writing them down.

(ii) To find out the situations that always tend to trigger certain negative thought patterns.

(iii) Think about the thinking mistakes we make and try to dispute them. While disputing the thoughts, we may bear the following in mind:

(i) Are my thoughts on this situation accurate?

(ii) What evident/facts do I have to support my view?

(iii) What alternative views are there on this situation?

(iv) Am I underestimating my ability to cope with the situation?

(v) What actions can I take to influence the present situation?

The next step is to:

(i) Develop new ways of thinking or more helpful beliefs that will lead to a new approach to dealing with the activating event (seeking treatment). Through constant practice, one will be able to start changing the stress-inducing thoughts that are not helpful and one will feel less pressured and happier. Also, it enables one to correct oneself from dysfunctional thinking on time so as not to go through emotional stress.

Session Wrap-up:

(i) The participants were encouraged to ask questions.

(ii) The researcher summarised the session and reminded them of the time and venue for the next session.

(iii) The participants were commended for their cooperation and participation.

Session 5:

Topic: Identification and Management of Psychological Distraction in Blame Attribution among Cancer Patients.

Objectives: By the end of the session, the participants were able to:

(i) Manage psychological distraction properly

(ii) Replace negative/disturbing/irrational thoughts with positive, less stressful and useful thoughts

Activities:

Step 1: The participants were welcomed warmly to the session while the researcher discussed the activities of the previous session with them.

Step 2: The researcher discussed identification and management of psychological distraction in blame attribution with the participants

Since cancer patients are thinking, evaluating, judging and enquiring beings, their altered thinking is the cause for attributing blame for their condition. These disordered thinking is responsible for alterations in mood and behaviour that characterise their psychological wellbeing and health status.

Blame attribution, together with its psychological, emotional and behavioural effects is a product of lingering illogical and irrational thinking.

By thinking more rationally, cancer patients would be able to avoid / eliminate attribution of blame which results into emotional disturbances, wrong attitude and unhappiness and will learn to think and act more logically and rationally by taking necessary steps towards management of cancer.

Step 3: The researcher and participants collaborated to identify basic negative cognitive distortions (such as catastrophising and exaggeration), together with the attitudes, beliefs and assumptions that shape their thinking i.e attributing the disease to someone or something else.

The participants were encouraged to always assume responsibility, face the reality of a situation and make a decision to resolve the issue at hand.

For example, Instead of dwelling on thoughts such as:

"I cannot be healthy unless my step mother/ enemy dies", one could create and adopt a positive mind frame such as: "I will do all within my power to combat this cancer disease by adhering to medical instructions".

The participants were assisted to confront their irrational thoughts with positive thoughts which will bring more hope for the future.

Step 4: The participants were assisted to enhance their self-confidence so that they can substitute the old mind frame with a new one devoid of attributing blame.

Session Wrap-up: (i) The participants were commended for their attention.

(ii)They were encouraged to seek clarifications on the just concluded session.

(iii)The researcher summarised the activities of the session.

Session 6:

Topic: Cognitive Distortions and Systematic Desensitisation in relation to Blame Attribution among Cancer Patients.

Objectives: By the end of the session, the participants were able to:

(i) Identify cognitive distortions

(ii) Eliminate irrational thinking

Activities:

Step 1: The participants were warmly welcomed. The researcher reviewed the contents of the previous session with the participants.

Step 2: The researcher described the effects of Blame Attribution as an emotional problem that makes an individual to view him/herself as inadequate, powerless and vulnerable thereby attributing his/her health condition to causes emanating from his/her thought patterns. These thoughts hinder the patient from seeking and adhering to proper medical help. The individual sees failure so easily and embrace it because of the thought that it emanates from somewhere, this state of unhappiness is often sustained by repeated, intrusive thoughts and cognitive distortions. These thoughts also hinder the participants from seeking proper medical help.

Step 3: The researcher defined and explained the meaning of cognitive distortions to the participants.

Cognitive distortions are those thoughts that people tend to have in their information processing system which lead them to faulty assumptions and misconceptions that fuel emotional and behavioural problems. These distortions usually operate in our automatic thoughts.

The researcher explained that psychological distress (such as anxiety) is activated by a set of three major cognitive patterns called cognitive triad. The cognitive triad forces individuals to view themselves negatively, have negative view of their environment and exhibit negative view of their future. She explained further that it has been established that certain faulty thought processes frequently run together. The cognitive triad are the negative automatic thoughts which center around people's understanding of themselves, others (the world) and the future.

Viewing Self in a Negative Way:

The individual with cognitive distortions sees himself as deficient, inadequate, and unworthy. He tends to attribute his unpleasant experiences to a physical, mental or moral defect in himself. Such individual shows less optimism towards a worthwhile task, believing he cannot cope or that such task is not meant for someone of his type. Furthermore, he regards himself as undesirable and worthless because of his presumed defect and tends to reject himself because of it. He regards an obstacle as an impossible barrier and interpretes difficulty in dealing with a problem as being a total failure. He views himself as incompetent and preoccupies himself with self-defeating thoughts which clouds his mind from perceiving reality of his situation. This situation leads him to manifest moodiness and signs of unhappiness.

Construing Experiences in a Negative Way:

These are maladaptive thinking patterns that distort reality in a negative way, and make us perceive the world as being more hostile than it actually is. The individual consistently interprets his interactions with his environment as representing defeat, deprivation and inability. The typical cognition show a variety of deviations from logical thinking, including overgeneralizations, polarised thinking, arbitrary selection, magnifications, etc. The individual automatically makes a negative interpretation of a situation even though more obvious and more plausible explanations exist. He tailors the facts to fit his negative conclusions.

Viewing the Future in a Negative Way:

The anxious individual anticipates that his current difficulties or challenge will continue indefinitely. As such person looks into the future, he sees a life of unremitting hardship, frustration, deprivation, uncertainty, helplessness and impossibility. Such individuals are encumbered with thoughts such as "It is not important" "What's the use? Nothing that I do makes the slightest difference" "Nobody will appreciate my slightest effort" "Things have gone out of control", etc.

Step 4: The researcher identified and discussed some examples of cognitive distortions also referred to as negative automatic thoughts.

All–Or–Nothing Thinking: Seeing things in black–and–white categories. For instance, seeing oneself as a total failure. An individual that could not perform a given task perfectly and who begins to assess him/herself as a never do well.

Arbitrary Inference: This refers to the drawing of an unjustified conclusion. For example, a man who does not talk about his wife getting additional academic qualification. His wife gets upset and concludes that he is not interested in her future. She neglects other possible explanations.

Polarized Thinking: An insistence on either-or choices is the key characteristics of this distortion: When an individual tends to perceive everything at the extremes, it leads to a black and white world, and consequently the individual will be robbed of all the shades of grey, the responses to happenings fluctuate between one emotional extreme to another. How an individual judges him/herself is a major danger with polarized thinking. If he/she is not brilliant or perfect, then he/she must be a completely stupid or failure. Mediocrity or mistakes is not tolerated.

Selective Abstraction or Mental Filtering: This is an act of picking out a single negative detail and dwelling on it exclusively so that the individual's vision of all reality becomes darkened, like the drop of ink that discolours the entire beaker of water. It involves focusing one's attention on one aspect of detail without pay attention to anything else. All individuals have personal particular filter type. Every suggestion of unfairness or injustice makes this type of people hypersensitive. This brings the individual to a state of frequent anger and resent. The hypersensitivity of others are to the least likelihood of danger (whether to self or a loved one) and frequently gets them

in a state of nervousness, worry, and fear. An individual may amplify and make awful his/her thoughts by the very process of filtering. When negative things are pulled out of perspective, taken out of all the pleasant experiences around, they become enlarged and highly awful than they really are. The outcome is that all one's irritations, losses, and fears become overstated in significance because they dominate one's awareness to the barring of every other thing. In other words, as an individual filters, he/she loses his/her sense of perspective and thinking becomes warped.

Overgeneralization: This involves assuming that one negative event constitutes a pattern of never-ending negative events. It is the drawing of a general conclusion based upon a limited event. It is a serious distortion that can affect one's sense of judgement via baseless conclusions about things and events. A victim of this distortion will not consider all evidences available concerning an event or situation but will rather base his or her conclusion on a single evidence or incident. Absolute statements are usually employed to embed overgeneralizations, this makes it looks like one's chances for happiness are limited by some law written in stone. Examples of overgeneralized thoughts include "everyone looks at me as being imperfect…, I cannot do anything correctly…, I'll never get a decent job..., I will always be sad..., Nobody understands me..., I'll never be able to trust anyone again..., My health condition cannot improve no matter what I do…" The conclusion is borne out of cautiously ignoring everything known about the individual that is different and only established on one or two pieces of evidence. Words such " nobody, everybody, all, always, every, never, and none," *a*re cue words that show an individual may be over generalizing.

Global labeling is a common form of over generalization. This happens when one makes an across-the-board statement intended at portraying an individual or group of persons ignoring the fact that human beings are complex and that our actions can viewed from different perspectives.

Personalisation: This is usually the case when an individual sees himself as the cause of some negative external event which in fact he was not primarily responsible for. An example is the case of a newly wedded man thinking that any feeling of tiredness expressed by his wife equates to the woman being tired of him. This is also exemplified by the perception as attacks on man's abilities as a breadwinner the ordinary complaints

about rising prices from his wife. The practice of persistently comparing oneself to other individuals is a foremost feature of personalization: "They are prosperous than us..., He is better with ladies relative to me..., They can use computer better than me…, I am not making any headway like them…, I was not givien a back brace but she was. My health is deteriorating more than other people's own". The occasions to compare is unending. The primary notion is that individual's sense of significance is doubtful. The individual is thus repeatedly required to ascertain his/her significance as an individual by assessing him/herself beside others. When he/she comes out better, he/she feels okay briefly, when he/she comes out inferior, he/she feels reduced in some ways. Interpretation of every experience, every discussion, every look as an evidence or proof of one's significance is the fundamental thinking error in personalization. Consequently, the individual ends up becoming a lot more irritated or depressed than it is necessary.

Magnification (Catastrophizing) or Minimization: Amplifying the significance of things (such as someone else's achievement) or improperly lessening things till they seem tiny (a person's desirable qualities or the other fellow's imperfections). This is also called the binocular trick. This has to do with blowing things out of proportion. They seem to envisage and anticipate the most awful likely outcomes. Usually, these catastrophic thoughts are usually initiated with words "what if." "what if the computer stops working...." "what if the system breaks…" "what if people laugh at me …" "What if the train derails..., What if this the ship sinks..., What if my wife jilts me for another man...".

Normally, catastrophes' occurrence is an obvious possibility, it is actually an infrequent one. Individuals who do it frequently move around acting as if a strike of catastrophe was intending or has actually taken place. They are always in "chain". Minimization on the other hands is the reverse of magnification. It is an undervaluation of positive attributes. A woman may have low self-esteem because she is not well-off. She neglects the respect that she commands for being an efficient employee, a good mother, a caring wife, a cheerful neighbour, and a loyal friend.

Labelling and Mislabelling: This is an extreme form of over-generalization. Instead of describing one error, the individual attaches a negative label to him/herself: "I am a loser", "I am never good ", "I know that I am a failure ", "I may not complete my

programme ". When someone else's behaviour rubs an individual the wrong way, the individual attaches a negative label to the person. Mislabeling involves describing an event with language that is highly coloured and emotionally loaded.

Should Statements: This distortional thought involves trying to motivate oneself with should and shouldn't, as if one had to be whipped and punished before one could be expected to do things. "Musts" and "Oughts" are also offenders. The emotional consequence is guilt. When one directs should statements towards others, the individual feels anger, frustration and resentment.

The distorted person uses inelastic and fixed rules on how s/he as well as other people must behave. Any departure from his/her exact fixed rules and standards is bad. Consequently, the individual frequently judges or finds faults. Such individuals are easily annoyed and irritated by others; believing they are not acting as expected. They possess undesirable opinions, habits, and traits that make them tough to bear with. They must demonstrate their knowledge of the rules by following them. Must should, or ought are cue words that indicate the presence of this distortion. The subjections to the long list of rules by these people are not only to other people, but similarly do same to themselves.Consequently, they escalate personal despair as they persistently fall short of the shoulds and musts. While it is perfectly normal to have preferences about how we and others should act this should be done rationally. Our expectations should not be absolute.

Examples of these are:

Mind Reading: A person arbitrarily concludes that someone is reacting negatively to him and he doesn't bother to check this out. For instance, "I can tell people don't like me because of the way they behave." Mind reading often involves a process called projection. An individual imagines that people feel the same way he/she feels and react to things the same way he/she react. Such person imagines everyone is angry when he is angry with someone or a situation. Individuals who are hypersensitive believe other individuals should be the same. They expect others to share their judgemental belief about specific traits and habits. Mind readers are hasty in drawing conclusions once they perceive them to be true not minding whether they are true with the other individual. Overreacting emotionally is the hallmark of individuals who habitually mind read in

negative ways. In other words, their emotions are prompted by their flawed assumptions about other people and not by actual facts. The assumptions are generally unverified though they are held as facts they are born of vague misgivings, hunches, intuition or a past experiences or the other.

The Fortune Teller Error: Anticipating that things will turn out badly and feel things will turn out badly and feel convinced that the prediction is an already-established fact.

Self-Worth: One makes an arbitrary decision that in order to accept oneself as worthy, okay, or to simply feel good about oneself, one has to perform in a certain way: usually most or at all the time.

Low Self-Regard: This represents thoughts that express an unjustified lack of self-confidence. It has to do greatly with viewing oneself in a negative way. An individual may regard himself as deficient, inadequate, or unworthy, and tend to attribute his unpleasant experiences to a physical, mental or moral defect or his inability to perform some tasks as expected. Such individual sees himself as undesirable and worthless. He tags an obstacle as an impossible barrier and sees difficulty in dealing with a problem as a total failure. Examples are: “I cannot do it." "I'm not as pretty as my friends." "Nobody will ever like me”. “I'm going to be a failure in life." "I don't deserve to live.". “I am the unfortunate type”.

Emotional Reasoning; Assumption that one negative emotion necessarily reflects the way things really are. For instance, ‘I feel it, therefore it must be true’ I thought as much, that must be the case.

Step 5: The researcher guided the participants towards dispelling all forms of cognitive distortions in order to reduce emotional distress and maintain good mental health.

Session Wrap-up:

(i) The participants were told to visualize the kinds of thoughts and feelings that cancer aroused in them for discussion.

(ii) The participants were commended for their attention.

(iii) They were encouraged to seek clarifications on the just concluded session.

(iv) The researcher summarised the activities of the session.

Session 7:

Topic: Using CR to Modify Thought Patterns/Use of breathing exercise with guided imagery

Objectives: By the end of the session, the participants were able to:

(i) Explain how CR works

(ii) Use CR to change their thought patterns

Activities:

Step 1: The participants were welcomed to the session and the researcher reviewed the activities of the previous session with them.

Step 2: The researcher shed more light on CR and how it works.

CR is a therapy that helps people live rational and productive lives. It helps people to realise that it is not the situation that is creating difficulties, unhealthy feelings and self-defeating behaviours but their thoughts and beliefs about the situation. Having more rational beliefs reduce conflicts with others and leads to improved health.

The researcher assisted the participants to identify, evaluate, dispute and act against irrational self–defeating beliefs which will make the clients feel and get better emotionally thereby seeking and adhering to medical treatment in order to combat the disease.

Step 3: The researcher discussed and visualised the association between thoughts, feelings and actions with the participants.

The researcher discussed with the participants how their thought patterns affect their emotion and behaviour. She also reviewed the concept of helpful beliefs. They were also trained on how to use CR to reshape their thinking about the causes of their present ailment. This is expected to lead to a new resolve and the desire to adhere to treatment.

Step 4: The participants were taught to use deep breathing and the power of imagination to bring up motivating scenes to their minds as they focus on the positive feelings and dispel the negative feelings.

Step 5: The participants were given opportunities to seek clarifications on the topic.

Session Wrap-up:

(i) The participants were commended for their attention.

(ii) The researcher summarised the activities of the session.

(iii) The participants were reminded of the time and venue for the next session

Session 8:

Topic: Summary, Post-test Administration and termination of therapy

Objectives: By the end of the session, the participants were able to:

(i) Discuss the benefits derived from the intervention programme and how they intend to reduce the occurrence of Blame Attribution in future.

(ii) Complete the post-test instrument.

Activities:

Step 1: The researcher welcomed all the participants to the last session of the intervention programme.

She appreciated them for their cooperation, regularity and punctuality throughout the programme.

Step 2: The participants were encouraged to explain what they have gained so far from the treatment programme and how they intend to ameliorate further manifestation or reoccurrence of Blame Attribution and all emotional problems attached to it.

Step 3: The participants were encouraged to freely ask questions concerning all the sessions of the intervention.

Step 4: The participants were informed of the importance of applying the knowledge gained during the intervention to solving psychological problems and were encouraged to put the newly acquired skills to practice.

Step 5: The post-test instrument was administered and completed with the help of the research assistants.

Session Wrap-up:

(i) The participants were encouraged to express any final thoughts or comments they have to share.

(ii) The participants were encouraged to fully utilise the skills they have acquired during the intervention programme.

(iii) The researcher ended the session by thanking the participants for being a meaningful part of the therapeutic encounter. She also acknowledged the honour and privilege of sharing in the participants' stories.

(iv) The researcher terminated the therapeutic session.

CONTROL GROUP

Session 1:

Topic: Introduction and Pre-test Administration

Objectives: By the end of the session, the researcher was able to:

(iv) Build a sound therapeutic alliance with the participants.

(v) Give the participants orientation about the structure and process of the study.

(vi) Administer the pre-test instruments to obtain the pre-test scores.

Activities:

Step 1: The researcher warmly welcomed the participants into the programme. She familiarised herself with the participants.

Step 2: The researcher established rapport between herself and the participants by creating an avenue for researcher/participants' introduction. The researcher ensured completion of informed consent forms in order to document their consent to participate in the study.

Step 3: The researcher provided an overview of the programme. She explained the purpose of the programme (research) and she solicited their support. The participants were assured of confidentiality during and after the research.

Step 4: The researcher and participants then agreed on the day and time for subsequent sessions. They also discussed the rules guiding the conduct of the research. The roles expected of the participants were explained and clarified.

Step 5: The pre-test instruments (Blame Attribution Scale, Social Support Scale and Health Self-Efficacy Scale) were administered to the participants with appropriate guidance from the researcher and the research assistants.

Session Wrap-up:

(i) The participants were commended for their cooperation and time.

(ii) The researcher encouraged them to attend the next session and reminded them of the day, time and venue.

Session 2:

Topic: Healthy Diet and Exercise

Objectives: By the end of the session, the participants were able to:

(i) Embrace healthy eating habits

(ii) Engage in simple exercises frequently

Activities:

Step 1: The researcher asked the participants what they understood by healthy diet.

Step 2: The researcher built on the participants' response and explained further that healthy diet is the intake of food in relation to the body's dietary needs**.** Healthy diet involves eating well balanced diet with a combination of the nutrients in the right proportions. It brings about increased immunity, productivity and reduced susceptibility to disease.

Step 3: The researcher explained things that they were expected to do in order to maintain healthy diet. Examples are: eating balanced diet, reducing intake of processed foods, eating adequate fruits, vegetables and dietary fibre, reducing intake of fat, eating more of boiled/steamed food than fried food.

Step 4: The researcher encouraged the participants to inculcate physical activities into their daily routine.

Step 5: The participants were given opportunity to seek clarifications where necessary.

Session Wrap-up:

(i) The participants were commended for their cooperation and time

(ii) The researcher encouraged them to attend the next session while reminding them of the day, time and venue.

Session 3:

Topic: Conclusion and Post-test Administration.

Objectives: By the end of the session, the participants were able to:

(i) Discuss the activities of the previous session.

(ii) Complete the post-test instrument.

Activities:

Step 1: The researcher welcomed all the participants to the last session of the programme.

She appreciated them for their cooperation, regularity and punctuality throughout the programme.

Step 2: The participants were encouraged to explain what they gained from the previous session.

Step 3: The post-test instrument was administered and completed with the help of the research assistants.

Session Wrap-up:

(i) The researcher brought the interaction to a closure by thanking the participants for being a meaningful part of the research. She also commended them for their time, cooperation and dedication.

(ii) The researcher terminated the therapeutic session.

3.8 Control of Extraneous Variables

The researcher guided against the effects of extraneous variables on the outcome of the study by taking into consideration appropriate randomization of participants in both experimental groups and the control group, adherence to the inclusion criteria, effective use of 3x2x2 factorial matrix design and the use of Analysis of Covariance (ANCOVA).

3.9 Data Analysis

Simple percentages and ANCOVA were the main statistical employed in the study. Simple percentages were used to analyse participants' demographics, while ANCOVA was used to establish initial differences between participants in the experimental and control groups. The post-hoc analysis of Scheffe was used in this study to determine the directions of differences and existing significance.

CHAPTER FOUR

RESULTS, INTERPRETATION AND DISCUSSION OF FINDINGS

This chapter focuses on the presentation and discussion of results and their interpretation. The discussion was done in relation to the previous empirical studies in connection with the variables of the study.

4.1 Data Analysis and Result

Table 4.1 indicates that participants' average age was 53.85±7.89 years. This implies that majority of the participants were between 51 and 60 years. Participants in the study were mostly females (88.9%) compared to males (11.1%) which is an indication that more females participated in the study than males. More so, 9.3% of the participants had no formal education, 22.2% had primary school education, 31.5% had secondary school education and 37% had tertiary education (OND, NCE, HND, BSc and its equivalents). Furthermore, 53.7% of the participants had breast cancer, a significant percentage of the population (33.3%) had cervical cancer, 9.3% had prostate cancer while 3.7% had skin cancer. In addition, majority of the participants (51.9%) were on stage 2 of the disease, 18.5% were on stage 1, 7.4% were on stage 3 while 22.2% participants' cancer stages were unknown.

Hypothesis One: There is no significant main effect of treatments on blame attribution among newly diagnosed cancer patients in southwestern, Nigeria

Table 4.2 above shows a significant main effect of treatment in managing blame attribution among newly diagnosed cancer patients ($F_{2;42}$ = 16.03; $P < 0.05$, $\tilde{\eta}$ = 0.43). This means that there is significant difference in the mean of managing blame attribution among newly diagnosed cancer patients that participated in the LT and CR training and the control. Hence, hypothesis one was rejected.

To further provide information in the management of blame attribution of the participants among the three groups (logotherapy,cognitive reframing and control), to ascertain the direction of the differences and the magnitude of the mean scores of the

participants in each of the treatments and the control group, the Scheffe post-hoc analysis was calculated and presented in table 4.3 showing that the CR therapy was most effective in the management of blame attribution of newly diagnosed cancer patients among the participants than the LT and the control groups respectively.

The following observations were made on Table 4.3:

1. There was a statistically significant difference between the post-hoc test mean scores in managing blame attribution among newly diagnosed cancer patients in the CR and LT groups. The participants in the CR (Mean=42.91) benefitted more than those in the LT (Mean=63.56).
2. There was a significant difference in the post-hoc test mean scores in managing blame attribution among newly diagnosed cancer patients exposed to CR and control groups. The participants in the CR (Mean=42.91) were able to manage blame attribution significantly than those in the control group (Mean=66.87).
3. There was a significant difference in the post-hoc test mean scores in managing blame attribution among newly diagnosed cancer patients exposed to LT and control groups. The participants in the LT (Mean=63.56) were able to manage blame attribution significantly than those in the control group (Mean=66.87).

This implies that the CR group obtained the lowest adjusted post–test mean score in managing blame attribution of newly diagnosed cancer patients ($\bar{x}$ = 42.91). This is followed by LT ($\bar{x}$ = 63.56) while the highest score was obtained by the Control group ($\bar{x}$ = 66.87). This implies that the CR therapy was most effective in the management of blame attribution of newly diagnosed cancer patients among the participants than the LT and the control groups respectively.

Hypothesis Two: There is no significant main effect of health self-efficacy on blame attribution among newly diagnosed cancer patients in southwestern, Nigeria.

The results from Table 4.2 shows that Health self-efficacy has significant effect on blame attribution among newly diagnosed cancer patients ($F_{1;42} = 6.09$; $P < 0.050$, $\tilde{\eta} = 0.13$). This means that there is significant main effect of Health self-efficacy on blame attribution among newly diagnosed cancer patients. Hence hypothesis two was not accepted. Further, Table 4.7 shows that participants with high health self-efficacy

benefited better from the treatment ($\bar{x}$ = 43.22) compared to participants with low health self-efficacy with ($\bar{x}$= 69.67).

Based on Table 4.4, participants with high health self-efficacy had a mean score of 43.22 while those with low health self-efficacy had a mean score of 69.67. Those with high health self-efficacy had lower post-treatment blame attribution rate than those with low health self-efficacy. Hence, participants in the high level benefitted more from treatment than those in the low level. Consequently, health self-efficacy has significant main effect in the management of blame attribution among newly diagnosed cancer patients.

Hypothesis Three: There is no significant main effect of social support on blame attribution among newly diagnosed cancer patients in southwestern, Nigeria

The results from table 4.2 showed that there is significant main effect of social supports on blame attribution among newly diagnosed cancer patients ($F_{1;42}$= 24.77; $P < 0.05$, ῆ = 0.37). This means that social support on blame attribution among newly diagnosed cancer patients with high and those with low social supports differ significantly. Hence hypothesis three was rejected. Further, Table 4.7 shows that participants with high levels of social support benefitted more from the treatment ($\bar{x}$= 43.65), followed by those with low levels of social support ($\bar{x}$ = 71.28). This implies that social support has significant main effect in the management of blame attribution among newly diagnosed cancer patients.

Hypothesis Four: There is no significant interaction effect of treatments (CR and LT) and health self-efficacy on blame attribution among newly diagnosed cancer patients in southwestern, Nigeria

The results from table 4.2 showed that there is no significant interaction effect of treatment and health self-efficacy on blame attribution among newly diagnosed cancer patients ($F_{2;42}$= 1.64; $P > 0.05$, ῆ = 0.73). This means that the interaction between treatment and health self-efficacy on blame attribution among newly diagnosed cancer patients has no significant impact. Hence hypothesis four was accepted.

Hypothesis Five: There is no significant interaction effect of treatments (CR and LT) and social support on blame attribution among newly diagnosed cancer patients in southwestern, Nigeria.

The results from Table 4.2 showed that there is no significant interaction effect of treatments and social support on blame attribution among newly diagnosed cancer patients ($F_{2; 42} = .076$, $P > 0.05$, $\eta^2 = 0.004$). This means there is no significant interaction effect of treatment and social support on blame attribution among newly diagnosed cancer patients. Hypothesis five was therefore accepted.

Hypothesis Six: There is no significant interaction effect of health self-efficacy and social support on blame attribution among newly diagnosed cancer patients in southwestern, Nigeria

The results from Table 4.2 showed that there is no significant interaction effect of Health Self-efficacy and social support on blame attribution among newly diagnosed cancer patients ($F_{1; 42} = 0.00$, $P > 0.05$, $\eta^2 = 0.00$). This means there is no significant interaction effect of health self-efficacy and social support on blame attribution among newly diagnosed cancer patients. Consequently, hypothesis six was accepted.

Hypothesis Seven: There is no significant three-way interaction effect of treatment, health self-efficacy and social support on blame attribution among newly diagnosed cancer patients in southwestern, Nigeria.

The results from Table 4.2 showed that there is no significant interaction effect of treatment, health self-efficacy and social support on blame attribution among newly diagnosed cancer patients ($F_{1; 42} = 3.39$, $P > 0.05$, $\eta^2 = 0.08$). This means there is no significant interaction effect of treatment, health self-efficacy and social support on blame attribution among newly diagnosed cancer patients. Hence, hypothesis seven was accepted.

Table 4.1: **Distribution of Participants' Demographics**

Age	Frequency	Percentage
21-30 years	1	1.9%
31-40 years	3	5.5%
41-50 years	17	31.5%
51-60 years	25	46.3%
61-70 years	7	12.9%
70 years and above	1	1.9%
Gender	**Frequency**	**Percentage %**
Male	6	11.1%
Female	48	88.9%
Educational Qualification	**Frequency**	**Percentage %**
None	5	9.3%
Primary	12	22.2%
Secondary	17	31.5%
Tertiary	20	37%
Cancer Type	**Frequency**	**Percentage %**
Breast	29	53.7%
Cervical	18	33.3%
Prostate	5	9.3%
Skin	2	3.7%
Stage of Cancer	**Frequency**	**Percentage**
Stage One	10	18.5
Stage Two	28	51.9
Stage Three	4	7.4
Unknown	12	22.2

Table 4.2: Summary of Analysis of Covariance (ANCOVA) showing the main effect of treatment groups, health self-efficacy and social support on blame attribution among newly diagnosed cancer patients.

Dependent Variable: Postest

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	20171.803[a]	11	1833.800	9.183	.000	.706
Intercept	3531.613	1	3531.613	17.684	.000	.296
Pretest	592.317	1	592.317	2.966	.092	.066
Treatmt	6401.614	2	3200.807	16.028	.000*	.433
HSEfficacy	1215.127	1	1215.127	6.085	.018*	.127
SSuppor	4947.124	1	4947.124	24.772	.000*	.371
Treatmt * HSEfficacy	656.041	2	328.020	1.643	.206	.073
Treatmt * SSuppor	30.267	2	15.134	.076	.927	.004
HSEfficacy * SSuppor	.001	1	.001	.000	.998	.000
Treatmt * HSEfficacy * SSuppor	677.364	1	677.364	3.392	.073	.075
Error	8387.530	42	199.703			
Total	200602.000	54				
Corrected Total	28559.333	53				

a. R Squared = .706 (Adjusted R Squared = .629)

*Denotes significant difference at 0.05 level of significance

Table 4.3: Summary of Scheffe Post-hoc Analysis showing Significant Differences in the Treatment and Control Groups

Trtgroup	N	Subset for alpha = 0.05		
		1	2	3
CR	21	42.91		
LT	18		63.56	
Control	15			66.87
Sig.		1.000	1.000	1.000

Table 4.4: Multiple Classification Analysis (MCA) showing the direction of differences among the treatment and control groups with health self-efficacy and social support in managing blame attribution among newly diagnosed cancer patients

Grand Mean = 56.4444

Variable + Category	N	Unadjusted Mean	Adjusted Mean	Unadjusted Deviation	Eta	Adjusted Deviation	Beta
Treatment:							
CR	21	42.905	44.550	-13.539		-11.894	
LT	18	63.556	63.356	7.111		6.911	
Control	15	66.867	64.803	10.422	.473	8.359	.413
Health Self Efficacy:							
High	27	43.222	49.378	-13.222		-7.066	
Low	27	69.667	63.511	13.222	.575	7.066	.307
Social Support:							
High	29	43.655	47.881	-12.789		-8.563	
Low	25	71.280	66.378	14.835	.599	9.934	.401
Multiple R Squared	.612						
Multiple R	.782						

4.2 Summary of Findings

The study examined logotherapy and cognitive reframing in the management of blame attribution among newly diagnosed cancer patients in southwestern, Nigeria. The findings are summarised as follows:

1. There was a significant main effect of treatment on blame attribution among the participants ($F_{2;42} = 16.03$; $P < 0.05$, $\tilde{\eta} = 0.43$).
2. There was a significant main effect of health self-efficacy on blame attribution among the participants ($F_{1;42} = 6.09$; $P < 0.050$, $\tilde{\eta} = 0.13$).
3. There was a significant main effect of social support on blame attribution among the participants ($F_{1;42} = 24.77$; $P < 0.05$, $\tilde{\eta} = 0.37$).
4. There was no significant interaction effect of treatment and health self-efficacy on blame attribution among the participants ($F_{2;42} = 1.64$; $P > 0.05$, $\tilde{\eta} = 0.73$).
5. There was no significant interaction effect of treatment and social support on blame attribution among the participants ($F_{2;42} = .076$, $P > 0.05$, $\eta^2 = 0.004$).
6. There was no significant interaction effect of health self-efficacy and social support on blame attribution among the participants ($F_{1;42} = 0.00$, $P > 0.05$, $\eta^2 = 0.00$).
7. There was no significant three way interaction effect of treatment, health self-efficacy and social support on blame attribution among the participants ($F_{1;42} = 3.39$, $P > 0.05$, $\eta^2 = 0.08$).

4.3 Discussion of Findings

This study investigated the effects of logotherapy and cognitive reframing on blame attribution among newly diagnosed cancer patients in southwestern Nigeria.

The demographic characteristics of the participants based on gender reveals that 88.9% of the participants were females while 11.1% were males. This implies that more females participated in the study than males. Participants' average age was 53.85±7.89 years. This clearly reveals that the highest percentage of participants were between 51 and 60 years. This is in line with literature both at the local and international level which indicates that age is a risk factor in cancer diagnosis. The distribution of participants based on educational qualifications shows that the highest number of participants (37%)

had tertiary education followed by those with secondary education (31.5%). Participants' distribution based on cancer type indicated that 53.7% had breast cancer. The implication of this is that breast cancer was the most prevalent cancer type among the participants. Further, majority of the participants were on stage 2 of the disease (51.9%).

Hypothesis One

The first hypothesis examined the significant main effect of treatment on blame attribution among newly diagnosed cancer patients in southwestern Nigeria. The results reveal that there was a significant main effect of treatment in the management of blame attribution among newly diagnosed cancer patients. This means that there is significant difference in the mean scores among the newly diagnosed cancer patients that participated in logotherapy, cognitive reframing and the control groups. Based on this, the hypothesis was rejected. The implication of this is that, logotherapy and cognitive reframing were effective in the management of blame attribution among newly diagnosed cancer patients who participated in the training. Using post-hoc analysis, the results show that cognitive reframing therapy was most effective in the management of blame attribution among the participants than the LT and control groups.

In a bid to further provide information on the management of blame attribution of the participants among the three groups (logotherapy, cognitive reframing and control), it is important to find the degree of significance among the groups. The Scheffe Post-Hoc Analysis was employed and it showed that there were significant differences between the post-hoc tests mean scores in the management of blame attribution among the participants in the three groups. The CR therapy was most effective in the management of blame attribution among the participants than the LT and control groups. This implies that those in the CR therapy group benefited more from the training than those in LT group and that the participants in LT group had better scores than those in the control group. This implies that CR decreases BA better than LT. These differences can be explained in terms of the efficacy of the different interventions and its respective delivery methods. This result could be attributed to the fact that CR is a cognitive based therapy that paid attention to how the participants attributed blame as a result of their thoughts, beliefs and attitudes which affected their feelings and behaviour. With CR, the

participants were able to acquire skills that would help them cope with their health condition successfully and disregard irrational thoughts about the cause of their illness.

The outome of this finding corroborates the findings of Jafari- Koulaee, Khenarinezhad, Abutalebi and Bagheri-Nesami (2018) who discovered that LT has a significant impact in reducing the level of depression in cancer patients. The result is also in consonance with the outcome of Mohabbat-Bahar, Golzari, Moradi-Joo and Akbari (2014) who also affirmed that LT is highly effective in reducing anxiety among Iranian women with breast cancer. In the same vein, LT has been found to be capable of improving the importance of daily living and the personal satisfaction of young people with terminal cancer and a preventive measure to guarantee young people in significant existential disorders as confirmed by Kang, Shim, Kim, Jeong, Song and Sim (2009). The findings of Southwick, Lowthert and Graber (2016) also proved the relevance and efficiency of LT in enhancing resilience to stress and trauma and its capability of assisting people with health and adjustment concerns to be resilient and adjust properly when faced with trauma and adversity.

Similarly, Shahabi (2016) affirmed that group logotherapy was very potent in improving optimistic life orientation and cancer patients' control of their emotions. Further, Ramesh *et al.*, (2014) while trying to ascertain the effect of group logotherapy on the mental health and hope to life of patients suffering from colorectal cancer, discovered immense advantage of applying logotherapy due to its potency in reducing distress associated with colorectal cancer as well as increasing hope in the sufferers. Aligning with this is the study of Ebrahimi, Bahari and Zare-Bahramabadi (2014) who reported that LT was capable of increasing hope of patients suffering from leukaemia. Thus, establishing a link between LT and BA and strengthening the potency of LT as being viable in the management of allegations and BA and positively affecting the levels of distress and the general sense of worthlessness among the patients.

In the same vein, the findings of Nader, Ghanbari, Tajabadi pour, Gholipour, Esmaeilzadeh (2019) confirmed that group logotherapy is effective in increasing the components of life expectancy and resilience in women with breast cancer, it can help women with breast cancer to find meaning in their life, receive support from groups, adapt themselves with diseases and it can be useful in breast cancer patient's attitude

towards hardships and problems and can increase their strength and resilience. Consistent with this finding is the report of Sun *et al*., (2019) who concluded that LT was effective in the reduction of breast cancer and gynecological cancer patients' depression and demoralization. This makes it evident that people who attended LT treatment cohorts were drawn from a pessimistic life direction to a constructive direction after the treatment period.

The outcome of this study is also in congruence with the findings of Lepore and Helgeson (2012) who discovered that CR was a basic tool that helped men with prostate cancer reinterprete terrible mishaps into reasonable situations and encourage flawed bits of their experience into a fair cognitive state during the period of being bothered. Consistent with this finding is the report of Pandey and Vajpeyi (2020) who indicated newly diagnosed cancer patients' coping mechanism, quality of life and life orientation were tremendously improved after being exposed to a 10-week psychological intervention with cognitive therapy and it also led to a reduction in the level of negative feelings. In line with this finding, Ofole and Omole (2017) reported that participants with learned helplessness who were exposed to CR had a higher mean score post-test compared with the control and self-acceptance therapy group. Also, CR was more potent in enhancing optimism in the participants than the self-acceptance treatment.

In the same vein, the potency of CR in reducing social disconnectedness among widows was reported by Moses (2021) as being significantly effective in reducing socially disconnected behaviour among the widows in the study. Similarly, Rosenberg, Jankowski, Fortuna and Rosenberg (2011) reported statistically significant improvements in Post Traumatic Stress Disorder and depression after exposing adolescents to CR. Asuzu *et al.* (2015) also reported the advantages of CR in reducing the extent of depression in female cancer patients through intervention. The participants who were trained with techniques in CR recorded a low level of depression when compared with the initial scores before the intervention. Similarly, Sulaiman and Uhuegbu (2021) supported the impact of CR as a viable strategy in the reduction of truancy among secondary school students.

This discovery further affirmed the findings of the following previous studies which proved the argument that cognitive-based therapies have clinical evidence for

treating diverse psychological problems Ezegbe, Ede, Eseadi, Nwaubani *et al*. (2018); Bhaskaran (2014); Blair (2004); Somani (2009); Fillion, Duval, Dumont, Gagnon, Sadeqee (2009); Hajibabaei, Kajbaf, Esmaeili, Harirchian and Montazeri (2020); Mardanivalendani and Ghafari (2015); Delaney, Barrere and Helming (2011); Kang, Shim, Jeon and Koh (2009); Tang, Chen and Cheng (2013); Mehrangiz *et al.* (2012); Hosseinigolafshani *et al.* (2020); Lepore and Helegson (2012); Pennebaker (2011); Van Kampen *et al*. (2014); Kang *et al.* (2009); Southwick *et al.* (2006); Zaiser (2005); Butler, Chapman, Foreman and Beck (2006). The consistency of those discoveries is essential, in that the mediation procedure achieved comparative outcomes. The CR approach helped the participants to change the cognitive biases being held by them. Also, LT assisted in improving their interpretation of life, how best to cope in undesirable situations and getting satisfaction in life.

Additionally, Linley and Joseph (2004) reasoned that cognitive change is usually detailed in around 30-70% of overcomers of different horrible conditions. Pandey and Vajpeyi (2020) also proved differences in the pre and post test conditions of newly diagnosed cancer patients' coping mechanism, quality of life and life orientation and a reduction in the level of negative feelings after being exposed to a 10-week psychological intervention with cognitive therapy. Also, Jafari- Koulaee *et al.* (2018); Mohabbat-Bahar *et al.* (2014); Southwick *et al.* (2016); Shahabi (2016); Ebrahimi *et al.* (2014) and Ramesh *et al.* (2014) all carried out experimental studies to prove the efficacy of LT in reducing negative outcomes among cancer patients. This implies that therapeutic intervention was effective and it further lays credence to the fact that blame attribution can be managed among cancer patients with the proper use of the therapeutic interventions.

Hypothesis Two

The second hypothesis stated that there was no significant main effect of health self-efficacy on blame attribution among newly diagnosed cancer patients in southwestern Nigeria. The results showed that health self-efficacy had significant effect on blame attribution among newly diagnosed cancer patients. This means that there was significant main effect of health self-efficacy on blame attribution among newly diagnosed cancer patients. The hypothesis was therefore rejected. This outcome is in

consonance with that of Seydel, Taal and Wiegman (1990); which revealed that result anticipations just as self-efficacy are great indicators of goal to take part in practices to identify breast cancer by undergoing self-breast assessment. In support of the present discoveries, self-efficacy has been found to be a significant impelling power in framing aims to practice and in keeping up the training a long time in maintaining health (Wiese and Klint, 2009). Self-efficacy has additionally demonstrated to be an amazing individual asset in adapting to pressure. There is additional proof that apparent self-efficacy in adapting to stressors influences resistant capacity. Subjects with high efficacy convictions were discovered to be in control of undesirable conditions over those with low self-efficacy.

In order to provide additional information in the management of blame attribution among newly diagnosed cancer patients in the two levels of health self-efficacy (high and low). The directions of the differences and the magnitude of the mean scores of the participants in each group was ascertained. The multiple classification post-hoc analysis showed significant differences between the mean scores of the participants. Participants with high health self-efficacy benefitted more from the treatment compared with participants with low health self-efficacy.

The justification for this finding can be explained in the sense that when newly diagnosed cancer patients believe in their confidence and capabilities to successfully engage in and execute necessary behaviours required to manage their condition, blame attribution can be properly managed by them. To further justify this finding, high health self-efficacy support has been found to be highly associated with overall wellbeing. People who receive high health self-efficacy are not probable to suffer from negative symptoms, they are likely to enjoy favourable health outcomes, improved recovery from illness and reduced risk of death from such conditions.

Hypothesis Three

The third hypothesis which stated that there was no significant main effect of social support on blame attribution among newly diagnosed cancer patients in southwestern Nigeria was rejected. The results from the analysis showed that there was significant main effect of social support on the management of blame attribution among newly diagnosed cancer patients. This means that the effect of social support on blame

attribution among newly diagnosed cancer patients with high and low social support differ significantly. It shows that participants with high social support benefited more from the treatment than the participants with low social support. This is in consonance with the findings of Bentur, Stark, Resnizky, and Symon's (2014) who discovered that the supportive role and connectedness of family and friends in a study of Israeli patients with advanced cancer and family connectedness enabled advanced cancer patients to cope with existential and spiritual concerns by providing comfort and support. Majaj, Nassar, and De-Allegri (2013) similarly confirmed that the supportive roles of participants' significant others were instrumental in enabling the women to engage in health-seeking behaviors by offering encouragement, support, and assistance. Consistent with this finding is the report of Pandey and Vajpeyi (2020) who concluded that having adequate social support is a very important tool needed to manage pain and suffering lack of which has negative consequences on the progression of the disease.

Conclusively, they stated that even though cancer is a disease that needs to be properly managed, having family and friends as sources of social support goes a long way in assisting them to cope adequately and positively with issues that may come up as a result of the diagnosis. Similarly, in another descriptive study carried out by Muhamad, Afshari and Kazilan (2011), it was inferred that when family members are supportive of cancer survivors in making decisions and in assisting with psychological issues, especially with the spouse being the main pillar of support, assisted by other members of the immediate and extended family, it was easy to cope with the condition and develop other strategies for enhanced quality of life and proper feeding habits. Consistent with this study is the finding of Kelly *et al.* (2019) and Van Ryn, Sanders, Kahn *et al*. (2011) who found the importance of social support in patients' treatment decisions, pain management and improved quality of life. Similarly, Khalili, Farajzadegan, Mokarian, and Bahrami (2013) confirmed that increased social support was associated with increased likelihood of survival of a disease.

The result of the finding is in congruence with the findings of Tanjasiri, Mata'alii, Hanneman and Sabado (2011); Maree and Mulonda (2015); Wonders *et al*. (2017); Kulik and Kronfeld (2005); Gilbar (2005); (Benson, Cobbold, Boamah, Akuoko, and Boateng, 2020); Koopman *et al.*, (1998); (Helgeson and Cohen, 1996); Cordova, Cunningham,

Carlson and Andrykowski (2001); Northouse, Templin and Mood (2001); Figueiredo, Fries and Ingram (2004); Primomo, Yates and Woods (1990); Reynolds, Hurley, Torres, Jackson, Boyd *et al.* (2000); Hirschman and Bourjolly (2005); Alferi, Carver, Antoni, Weiss and Duran (2001); Halford, Scott and Smythe (2000); **(**Baider, Koch, Esacson and De-Nour, 1998); Peters-Golden (1982); Pistrang and Barker (2002); Hoskins, Baker, Sherman, Bohlander, Bookbinder *et al.* (1996); Maly, Umezawa, Leake and Silliman (2005); Wimberly, Carver, Laurenceau, Harris and Antoni (2005); Pearlin and Skaff (1996); Mui and Morrow-Howell (1993); Muhamad, Afshari and Kazilan (2011); Halford, Scott, and Smythe (2010); (Northouse, 1989); Baider, Koch, Esacson and De-Nour (1998); Pistrang and Barker, 2002.

Thus, a positive relationship has frequently been established between social support and adjustment with respect to psychological functioning. Getting a diagnosis of cancer has a profound effect on patients and their families. A companion is especially being affected as a result of dread and vulnerability about treatment, lack of proper functioning, torment, and monetary dangers in treatment expenses and lost income and eventually personal satisfaction. In a similar vein, the reactions and adapting styles of the life partner and cancer understanding likewise are significant. Positive supportive adapting happens when accomplices help the other accomplice by means of an assortment of instruments including: expressions of shrewd direction, imparting confidence in the other accomplice's capacities, and articulations of solidarity.

Contrarily, in a study by Saeed, Asim and Sohail (2021) on the fears, barriers and problems in breast cancer diagnosis and treatment, it was found that women with breast cancer face lack of social and emotional support from family and other relationships. Due to the perceived insensitive behaviour of people, patients avoid meeting friends and neighbours. Consequently, the patients choose to spend more time in isolation as they do not want to face people. Hence, prefering social isolation over available social support to avoid negative body image evaluation of their bodies.

Hypothesis Four

The result of the fourth hypothesis demonstrated that there was no significant interaction effect of treatments and health self-efficacy on blame attribution among newly diagnosed cancer patients in southwestern Nigeria. Therefore, the hypothesis was accepted. This means that the interaction between treatment and health self-efficacy on blame attribution among newly diagnosed cancer patients has no significant impact. In contrast with this outcome, Barlow, Bancroft and Turner (2005) confirmed that self-efficacy may reinvigorate cancer patients, increase their certainty of overcoming the problems related to the disease and its treatment and improving their personal satisfaction. Their findings corroborate those of Bhaskaran (2014); Pellebon and Anderson (1999) and Schroevers, Helgeson, Sanderman and Ranchor (2010). As an outcome of acting outside of their own worth framework, in any event, when they are not completely mindful of what that worth framework involves, such youth regularly feel in strife with themselves and as often as possible show side effects of insignificance, sorrow or other psychological wellness issues. In any case, when allowed the chance to examine and explain their qualities and objectives, they increase self-mindfulness and a more clear feeling of character and stick to an individual worth framework, with the outcome being that their pointlessness and burdensome manifestations diminish. The discoveries of these studies are not in consonance with the present study.

Hypothesis Five

Hypothesis five stated that there was no significant interaction effect of treatments and social support on blame attribution among newly diagnosed cancer patients in southwestern Nigeria. The results indicated that there was no significant interaction effect of treatment and social support on blame attribution among newly diagnosed cancer patients. The hypothesis was therefore accepted. This means there was no significant interaction effect of treatment and social support on blame attribution among newly diagnosed cancer patients. This is in contrast with the findings of Peterson and Seligman (2003) and Blair (2004). Of the three kinds of support, the most investigated is emotional support coupled with its connection to psychosocial outcomes in ladies experiencing breast cancer. Numerous measures of emotional support are related to outcomes in breast

cancer. For example, women who talk more with others about their experience of breast cancer achieve greater well-being.

Hypothesis Six

The results obtained on testing hypothesis six indicated that there was no significant interaction effect of health self-efficacy and social support on blame attribution among newly diagnosed cancer patients in southwestern Nigeria. The hypothesis was therefore rejected. In contrast with this finding, Peters-Golden (2002) concluded that problems of adjustment is traced to insufficient support from a partner. This is exemplified in the fact that better adjustment is reported by women having spouses who render understanding and support. Conversely, women undergoing higher levels of distress are those with spouses with the inability to provide support during the experience of breast cancer.

Additionally, a problematic partner relationship is not compensated for through having a good helping relationship with another person (Pistrang and Barker, 2002). This indicates that the effect the partner relationship provides cannot offset or be equivalent to that of other relationships (Hoskins *et al.*, 1996; Beck and Lund, 1981; Seydel, Taal and Wiegman, 1990).

Hypothesis seven

Hypothesis seven was acknowledged as there was no significant three-way interaction effect of treatment, health self-efficacy and social support on blame attribution among newly diagnosed cancer patients in southwestern Nigeria. This finding is in disagreement with Pennebaker (2011) who proposed that communicating one's understanding to a confided individual places some structure on the experience, in this way encouraging positive reappraisal of the situation. Through sharing after some time, the men with prostate cancer started to sort out and structure their treatment experience so that events turned out to be increasingly reasonable. This study also supports the works of Azizi, Bahadori and Azizi (2013) and Walker, Pratt and Wood (1993). These results are explained in terms of opportunity outside the care giving role to evaluate oneself and reshape self-concepts. The number of relationships one has decreases as people age. In addition, care giving often requires the reduction of time spent engaging in these outside relationships (Bodnar and Kiecolt-Glaser, 2004).

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter presents the conclusion and recommendations of the study based on the result of the findings. The limitations of the study were highlighted, the study finally proffered suggestions for further studies and made contributions to knowledge.

5.1 Conclusion

The study examined the effectiveness of logotherapy (LT) and cognitive reframing (CR) in the management of blame attribution among newly diagnosed cancer patients in southwestern Nigeria. Health self-efficacy and social support were the moderating variables in the study. Participants were trained with the therapeutic packages, data were collected and analysed. The study found that there was significant main effect of treatment in managing blame attribution among newly diagnosed cancer patients. This implies that both LT and CR were effective in the management of blame attribution among cancer patients. As shown in the results, CR therapy was more effective in managing blame attribution among the participants than LT.

Also, the outcome of the present study showed that health self-efficacy has significant effect on blame attribution among the participants. In the same vein, social support has a significant main effect on blame attribution among newly diagnosed cancer patients. Participants with high levels of social support benefited more from the treatment than those with low levels of social support. Based on the findings of this study, it is concluded that the two interventions used in the study had shown effectiveness in the management of blame attribution among newly diagnosed cancer patients.

It is further concluded that following a cancer diagnosis, it is important for patients to undergo complete treatment in order to properly manage the disease and live a well adjusted life. This may not be achievable if such patients refuse to seek or run away from medical treatment when faced with such diagnosis. The two therapies used in the study have therefore demonstrated potency and effectiveness in managing blame

attribution of newly diagnosed cancer patients in southwestern Nigeria and the need to fully incorporate psychosocial support into all oncology settings.

5.2 Implication of Findings

The outcome of this study has shown clearly that logotherapy (LT) and cognitive reframing (CR) are effective in the management of blame attribution among newly diagnosed cancer patients in southwestern Nigeria. Therefore, this study has policy implications on clinical practice for the participants, other cancer patients, their caregivers, health care providers, clinical and counselling psychologists, policy makers and researchers.

First, the study has established the challenges associated with patients' rates of blame attribution and has identified psychological interventions capable of managing the identified problem of attributing blame in illness. LT and CR have proved to be effective therapies for managing newly diagnosed cancer patients with high levels of blame attribution. Thus, providing empirical evidence in literature to show the relationship among the variables. This suggests that these therapies may also be useful for treating cancer patients with other adjustment, emotional and psychosocial problems. Also, it has been established that increased levels of social support and health self-efficacy have a lot of positive influence on the reduction of blame attribution among the participants while low levels of social support and health self-efficacy may aggravate blame attribution.

Further, the participants have been exposed to psychological interventions that have helped them to reduce the rates at which they attribute blame and improve on their behavioural attitude and willingness to seek medical help. The knowledge gained during the training will also be useful in overcoming psychosocial issues relating to cancer diagnosis. These therapies can also be applied to other individuals who develop similar behavioural patterns especially as it relates to blame attribution in illness and diseases.

Clinical and counselling psychologists need to take cognisance of the fact that a diagnosis of cancer can lead to emotional problems which make adherence to treatment and adjustment process very difficult. It is a limiting factor to proper management of and recovery from the disease. Hence, there is the need to develop proactive measures in

managing blame attribution and other psychosocial problems associated with cancer diagnosis among newly diagnosed cancer patients.

For policy makers, the findings of this study can be utilized to form or amend policies and make decisions with regards to cancer patients ranging from screening, diagnosis, treatment, palliative care to end of life (if applicable). They can also formulate plans and strategies that the government, healthcare experts, and other relevant professionals will utilize to enable the cancer patients receive optimal care throughout the illness trajectory.

5.3 Recommendations

Based on the findings of this study, the following recommendations are highlighted for consideration:

- There is the need for increased sensitisation, enlightenment and awareness on the importance of screening and testing for cancer. This will raise awareness on the benefits of cancer testing to assist the patients in making an informed decision and to avoid wrong attribution.
- Counselling, clinical psychologists and other related professionals could utilise LT and CR as effective interventions in the management of blame attribution among cancer patients.
- A lot of cancer patients have attributed blame regarding the cause of their ailment. This has led to increase in emotional problems and a deteriorating state of health. Participants should therefore make use of the skills learnt during the course of this intervention programme to reduce emotional problems associated with blame attribution.
- Cancer patients' family members and the society at large should show empathy and support in the provision of psychological and financial needs. This is very important so that the affected patients would feel loved and be able to adjust considerably.
- Cancer patients and their caregivers should seek the help of professional psychologists in resolving some of the psychosocial challenges they experience

such as blame attribution, negative feelings and suicidal ideations that have negative effects on their quality of lives.

- The interventions could be delivered to a larger sample size by incorporating them into routine care for patients who indicate clinically relevant levels of distress in Nigerian cancer centres.
- Further efforts in developing more psychosocial interventions for cancer patients are needed to ensure that cancer patients who have psychosocial needs will have such available to them.
- Policy makers could draw inference from this study to establish functional counselling units in hospital settings at all levels. This would go a long way in putting adequate psychological interventions into effective use by trained professionals as well as having positive impacts in ameliorating psycho-social issues affecting cancer patients generally.

5.4 Contributions to Knowledge

The following are the contributions of the study to knowledge:

The study has proven to participants, caregivers and health care providers that blame attribution is a problem and that it can be managed among affected individuals when faced with cancer diagnosis. Also, when properly managed, patients become better adjusted and have improved quality of life as they engage in their day to day activities and as they go through the treatment procedure.

The study has been able to justify the effectiveness of logotherapy (LT) and cognitive reframing (CR) in the management of blame attribution among newly diagnosed cancer patients. In essence, proper application of the techniques of each therapy is capable of leading to better psycho-social outcomes in the patients. Cognitive reframing was more effective in the management of blame attribution among the participants. This no doubt, serves as an eye opener in research in terms of the effectiveness of other sub-components of cognitive therapy such as systematic desensitization, modification of thought pattern amongst others.

The findings in this study served as a source of reference for other researchers who may want to conduct the same or similar studies in other areas or parts of the

country. It has also provided empirical data to assist clinical psychologists and other stakeholders in the health sector. The findings from this study also reveals that it is imperative that support groups should be made available to cancer patients in order for them to benefit from emotional and informational support.

5.5 Limitations of the Study

This study investigated the effects of logotherapy and cognitive reframing in the management of blame attribution among newly diagnosed cancer patients in southwestern, Nigeria. The researcher encountered the following limitations which are worthy of note in the course of carrying out the study:

The study was only carried out in the southwestern Nigeria, and three (3) hospitals were used while others were unable to benefit from the training programme.

Despite efforts made by the researcher in recruiting eligible participants on a voluntary basis and sustaining them for the eight weeks training, only 54 out of the 63 participants recruited initially were able to attend the complete sessions of the training and the intervention programme. The fifty four (54) participants appear to be low compared to the number of newly diagnosed cancer patients in the southwestern part of Nigeria. Therefore, the small sample size limits the extent to which the results can be generalized.

The interventions were limited to eight (8) sessions due to the peculiarity of the participants. A longer period could be considered in the delivery of the interventions in the future to ensure more favourable results. Also, the dearth of empirical literature from Nigeria on the treatment interventions, causes and prevalence of blame attribution among cancer patients is another limitation to this study. This dearth, to some extent, affects the robustness of discussion of the findings of the study.

The moderating variables used in this study were health self-efficacy and social support leaving out other organismic and environmental factors like anxiety, socio-economic status, gender and educational background amongst others. However, these limitations are not enough to rob the research of its quality and validity.

5.6 Suggestions for Further Studies

This study investigated the effectiveness of logotherapy and cognitive reframing in the management of blame attribution among newly diagnosed cancer patients in southwestern Nigeria. It also went further to examine the moderating effects of social support and health self-efficacy of the participants in influencing the effects of the treatment. In view of this, the study could be replicated in other parts of the country. This study was also limited to three hospitals in the southwestern Nigeria, the researcher therefore suggests a further expansion of the scope to include other geo-political zones of Nigeria to broaden the generalizations of this study.

A similar study could also be conducted over a longer period of time to give cancer patients more opportunity to internalize the teachings from the psychotherapeutic strategies. A longitudinal study could also be conducted to consider other moderating variables such as, religiosity, socio-economic status and cultural orientation. Also, logotherapy and cognitive reframing could be applied to the management of other emotional and behavioural problems associated with cancer diagnosis.

REFERENCES

Abramson, L.Y., Seligman, M.E. and Teasdale, J.D. 1978. Learned Helplessness in Humans: Critique and Reformulation. *Journal of Abnormal Psychology* 87(1):49-74.

Adam, A. and Koranteng, F. 2020. Availability, Accessibility and Impact of Social Support on Breast Cancer Treatment among Breast Cancer Patients in Kumasi, Ghana: A Qualitative Study. PLoS ONE 15(4): e0231691.

Adamo, D.T. 1999. African Cultural Hermeneutics. In Vernacular Hermeneutics, Surgitharajab RS (ed), Sheffield Academic Press: England.

Adebamowo, C. A. and Ajayi, O.O. 2000. Breast Cancer in Nigeria. *West African Journal of Medicine* 19(3):179-191.

Adeoti, M.L., Olugbenga-Bello, A. and Jegede, O. 2016. Colorectal Cancer: Knowledge and Risk Factors among Adults in a Suburban Nigerian Community. *Journal of Medical Science And Clinical Research* 10.18535/jmscr/v4i9.28.

Affleck, G., Tennen, H., Croog, S. and Levine, S. 1987. Causal Attribution, Perceived Benefits and Morbidity after a Heart Attack: An 8-year Study. *Journal of Consulting and Clinical Psychology* 55(1):29-35

Affleck, G., Tennen, H., Pfeiffer, C. and Fifield, J. 1987. Appraisals of Control and Predictability in Adapting to a Chronic Disease. *Journal of Personality and Social Psychology* 53:273-279.

Aghajani, M., Akbari, B., Khalatbari, J. and Sadighi, A. 2018. Effectiveness of Group Logotherapy on Feeling Loneliness and Psychological Hardiness of the Girls Suffering From Love Trauma Syndrome. *Armaghane-Danesh Open Access Journal* 23(5):559-76.

Ajekigbe, A.T. 1991. Fear of Mastectomy: The Most Common Factor Responsible for Late Presentation of Carcinoma of the Breast in Nigeria. *Journal of Clinical Oncology* (30):78–80.

Ajzen, I. and Fishbein, M. 1980. Understanding Attitudes and Predicting Social Behaviour. NJ: Prentice-Hall.

Ajzen, I. 1991. The Theory of Planned Behaviour. *Organisational Behaviour and Human Decision Processes* 50:179-211.

Akanbi, O.O., Oguntola, A.S., Adeoti, M.L., Aderounmu, A.O.A., Idris, O.L. *et al*. 2015. Delay Presentation of Breast Cancer: A Study among Southwestern Nigerian Women. *International Journal of Current Research* 7(8):19035-19039.

Akuoko, C.P., Armah, E., Sarpong, T., Quansah, D.Y., Amankwaa, I. *et al*. 2017. Barriers to Early Presentation and Diagnosis of Breast Cancer among African Women Living in Sub-Saharan Africa. PLoS One:12(2).

Albrecht, T. and Adelman, M. 2006. Communicating Social Support. *Journal of Communication* 56:(1).

Alferi, S.M., Carver, C.S., Antoni, M.H., Weiss, S. and Durán, R.E. 2001. An Exploratory Study of Social Support, Distress and Life Disruption among Low-income Hispanic Women under Treatment for Early Stage Breast Cancer: *Journal of Health Psychology* 20:41-46.

Altmaier, E.M., Russell, D.W., Kao, C.F., Lehmann, T.R. and Weinstein, J.N. 1993. Role of Self-efficacy in Rehabilitation Outcome among Chronic Low Back Pain Patients. *Journal of Counselling Psychology* 40:335-339.

Ameli, M. and Dattilio, F.M. 2013. Enhancing Cognitive Behaviour Therapy with Logotherapy: Techniques for Clinical Practice. *Journal of Psychotherapy* 50(3):387-91.

Ameli, M. 2016. Integrating Logotherapy with Cognitive Behaviour Therapy: A Worthy Challenge. In A. Batthyany (Ed.), Logotherapy and Existential Analysis: Proceedings of the Viktor Frankl Institute Vienna 1: 197–217. Cham: Springer International Publishing.

American Cancer Society, 2017. Cancer Facts and Figures. Atlanta: Accessed 31 October, 2018.

………., 2016. Cancer Facts and Figures. Atlanta: Accessed 31 October, 2018.

American Society of Human Genetics, 1995. American College of Medical Genetics: Ethical, Legal, and Psychological Implications of Genetic Testing in Children and Adolescents. *Journal of Human Genetics* 57:1233–1241

Anderson, E.S., Wojcik, J.R., Winett, R.A. and Williams, D.M. 2006. Social-cognitive Determinants of Physical Activity: The Influence of Social support, Self-efficacy, Outcome Expectations, and Self-regulation among Participants in a Church-based Health Promotion Study. *Journal of Health Psychology* 25:510–520.

Anguiano, L., Mayer, D. K., Piven, M. L. and Rosenstein, D. 2012. A Literature Review of Suicide in Cancer Patients. *Journal of Cancer Nursing* 35(4):14–26.

Anyanwu, S.N. 2000. Breast Cancer in Eastern Nigeria: A Ten Year Review. *West African Journal of Medicine* 19 (2):120-5.

Anyanwu, S.N., Egwuonwu,O.A. and Ihekwoaba, E.C. 2011. Acceptance and Adherence to Treatment among Breast Cancer Patients in Eastern Nigeria. *Journal of Scientific Research Publishing* 20:51–53.

Asobayire, A. and Barley, R. 2014. Women's Cultural Perceptions and Attitudes Towards Breast Cancer: Northern Ghana. *Journal of Health Promotion* 30 (3), 647–657.

Asuzu, C. C. and Akin-Odanye, E. O. 2015. The Delivery of Psychosocial Services in an Oncology Setting: The Ibadan Experience. *Journal of Clinical Trials* 5:228.

Asuzu, C.C. and Asuzu, M.C. 2007. Knowledge, Attitude and Practice of Self Breast Examination among the Female Students of the University of Ibadan, Nigeria. *Pakistan Journal of Social Science* 4 (3):400-402.

Asuzu, C.C., Akin-Odanye, E.O and Philip, E.J. 2015. The Effect of Pilot Cognitive Restructuring Therapy Intervention on Depression in Female Cancer Patients. *Journal of Psycho-Oncology* DO.I: 10:1002/pon 3950. wileyonlinelibrary.com

Asuzu, C.C., Elumelu-Kupoluyi, T., Asuzu, M.C., Campbell, O.B., Akin- Odanye, E.O. *et al*. 2015. A Pilot Study of Cancer Patients' Use of Traditional Healers in the Radiotherapy Department, University College Hospital, Ibadan, Nigeria. *Journal of Psycho-Oncology* do.i:10.1002/

Asuzu, C.C., Akin-Odanye, E.O., Asuzu, M.C., *et al*. 2019. A Socio-cultural Study of Traditional Healers' Role in African Health Care. *Journal of Infectious Agents and Cancer* 14:15 https://doi.org/10.1186/s13027-019-0232-y

Asuzu, C.C., Elumelu-Kupoluyi, T., Asuzu, M.C., *et al*. 2017. A Pilot Study of Cancer Patients' Use of Traditional Healers in the Radiotherapy Department, University College Hospital, Ibadan, Nigeria. *Journal of Psycho-Oncology* 26:369–76.

Azizi, M.H., Bahadori, M. and Azizi, F. 2013. History of Cancer in Iran. *Archives of Iranian Medicine* 16 (10):613-622.

Baider, L., Ever-Hadani, P., Goldzweig G., Wygoda, M.R., Peretz, T. 2003. Is Perceived Family Support a Relevant Variable in Psychological Distress? A Sample of Prostate and Breast Cancer Couples. *Journal of Psychosomatic Research* 55(5):453-60.

Baider, L., Koch, U., Esacson, R. and De-Nour, A. K. 1998. Prospective Study of Cancer Patients and their Spouses: The weakness of Marital Strength: *Journal of Psycho-Oncology* 7:49-56.

Bandura A. 1991. Social Cognitive Theory of Self-regulation. *Organizational Behaviour and Human Decision Processes* 50:248–287.

………. 1994. Self-efficacy. In V. S. Ramachaudran (Ed.), Encyclopedia of Human Behaviour 4:71-81. New York: Academic Press.

………. 1977. Self-efficacy: Toward a Unifying Theory of Behavioural Change. *Psychology Review 84*:191-215.

………. 1991. Self-efficacy Conception of Anxiety. In R. Schwarzer and R.A. Wicklund (Eds.), Anxiety and Self-focused Attention (pp. 89-110). New York: Harwood.

………. 1992. Self-efficacy Mechanism in Psychobiologic Functioning. In R. Schwarzer (Ed.), Self-efficacy: Thought Control of Action (pp. 355-394). Washington, DC: Hemisphere.

………. 1997. Self-efficacy; The Exercise of Control. New York: Freeman and Company.

………. 1999. A Social Cognitive Theory of Personality. In L. Pervin & O. John (Eds.), Handbook of Personality (2nd. ed., pp. 154-196). New York: Guilford Publications.

………. 1986. Social Foundations of Thought and Action: A Social Cognitive Theory. New Jersey: Prentice Hall.

………. 1989. Human Agency in Social Cognitive Theory. *American Psychologist* 44:1175–1184.

Bandura, A., Cioffi, D., Taylor, C.B. and Brouillard, M.E. 1988. Perceived Self-efficacy in Coping with Cognitive Stressors and Opioid Activation. *Journal of Personality and Social Psychology* 55:479-488.

Bandura, A., O'Leary, A., Taylor, C.B., Gauthier, J. and Gossard, D. 1987. Perceived Self-efficacy and Pain Control: Opioid and Non-opioid Mechanisms. *Journal of Personality and Social Psychology* 53(3):563-71.

Banerjee D, Gidwani C. and Sathyanarayana Rao, T S. 2020. The role of "Attributions" in Social Psychology and their Relevance in Psychosocial Health: A Narrative Review. *Indian Journal of Social Psychiatry* 36:277-83.

Barling, J. and Abel, M. 1983. Self-efficacy and Tennis Performance. *Cognitive Therapy and Research 7*:265-272.

Barlow, J., Bancroft, G. and Turner, A. 2005. Self-management Training for People with Chronic Disease: A Shared Learning Experience. *Journal of Health Psychology* 10(6):863–72.

Bates, M.S., Rankin-Hill, L. and Sanchez-Ayendez, M. 1997. The Effects of Cultural Context of Health Care on Treatment and Response to Chronic Pain and Illness. *Journal of Social Science Medicine* 45:1433-1447.

Beck, A.T. ,Wright, F.W., Newman, C.F. and Liese, B. 1993. Cognitive Therapy of Substance Abuse New York, NY: Guilford; Conner R.J. Abnormal Psychology New York: Freeman and Company.

Beck, A.T. 1997. The Past and the Future of Cognitive Therapy. *Journal of Psychotherapy, Practice and Research* 6:276-284.

………. 2005. The Current State of Cognitive Therapy: A 40 year Retrospective. *Archives of General Psychiatry* 62(9):953-9.

Beck, K. H. and Lund, A. K. 1981. The Effects of Health Threat Seriousness and Personal Efficacy upon Intentions and Behaviour. *Journal of Applied and Social Psychology* 11:401-415.

Beck, A. T., Rush, A. J., Shaw, B. F. and Emery, G. 1979. Cognitive Therapy of Depression. New York: Guilford Press.

Beckham, J.C., Rice, J.R, Talton, S.L., Helms, M.J. and Young, L.D. 1994. Relationship of Cognitive Constructs to Adjustment in Rheumatoid Arthritis Patients. *Cognitive Therapy and Research* 18:479–496.

Benson, R.B., Cobbold, B., Boamah, E.O., Akuoko, C.P and Boateng, D. 2020. Challenges, Coping Strategies, and Social Support among Breast Cancer Patients

in Ghana. *Journal of Advances in Public Health* https://doi.org/10.1155/2020/4817932.

Bentur, N., Stark, D., Resnizky, S. and Symon, R. 2014. Coping Strategies for Existenctial and Spiritual Suffering in Israeli Patients with Advanced Cancer. *Israel Journal of Health Policy Research* 3:21.

Bhaskaran, K. 2014. Body Mass Index and Risk of 22 Specific Cancers. *Lancet* 384 (9945):755–765.

Binka, C., Nyarko, S.H., Awusabo-Asare, K. and Doku, D.T. 2018. ‘I always tried to forget about the condition and pretend I was healed’: Coping with Cervical Cancer in Rural Ghana. *Journal of Palliative Care* 17(1):24.

Birhanu, Z., Abdissa, A., Belachew, T., *et al*. 2012. Health Seeking Behaviour for Cervical Cancer in Ethiopia: A Qualitative Study: *International Journal of Equity Health* 11(1):83

Blair, R.G. 2004. Helping Older Adolescents Search for Meaning in Depression. *Journal of Mental Health Counselling* 26:333-347.

Block, S.L., Nolan, T., Sattler, C., Barr, E., Giacoletti, K.E. *et al*. 2006. Comparison of the Immunogenicity and Reactogenicity of a Prophylactic Quadrivalent Human Papillomavirus (types 6, 11, 16, an.d 18) L1 Virus-like Particle Vaccine in Male and Female Adolescents and Young Adult Women. *Journal of Peadiatrics* 118(5):2135-2145.

Bodnar, J. and Kiecolt-Glaser, J.K. 1994. Caregiver Depression after Bereavement: Chronic Stress isn't over when it's over. *Journal of Psychology and Aging* 9:372–380.

Boeree, C.G. 2006. Personality theories: Viktor Frankl. Retrieved from http://webspace.ship.edu/cgboer/frankl.html

Bolger, N., Foster, M., Vinokur, A. and Ng, R. 1996. Close Relationships and Adjustments to a Life Crisis: The Case of Breast Cancer; *Journal of Personality and Social Psychology* 70:283-294.

Bower, J.E., Kemeny, M.E., Taylor, S.E. and Fahey, J.L. 1998. Cognitive Processing, Discovery of Meaning, CD4 Decline, and AIDS-related Mortality among Bereaved HIV-Seropositive Men. *Journal of Consulting and Clinical Psychology 66*(6): 979–986.

Brown, B.J. and Adeleye, A.O. 2017. Relationship of Socio-economic Status and Childhood Cancer: An In-hospital Cross-sectional Study in a Developing Country. *Nigeria Journal of Paediatrics* 44(4):180–184.

Bulman, R.J. and Wortman, C.B. 1977. Attributions of Blame and Coping in the “Realworld”: Severe Accident Victims React to their Lot. *Journal of Personality and Social Psycology* 35(5):351-363.

Busuttil, A., Moulton-Perkins, A. and Tuite, M. 2015. Working with People with Physical Health Problems. In Davey, G., Lake, N. and Whittington, A, 2015 (eds). Topics in Applied Psychology; Clinical psychology (Second Edition). Routledge, London and New York (pp. 216-235).

Butler, A.C., Chapman, J.E., Foreman, E.M. and Beck, A.T. 2006. The Empirical Status of Cognitive-behavioural Therapy: A Review of Meta-analyses; *Journal of Clinical Psychology Review* 26 (1):17-37.

Butler, L.D., Blasey, C.M., Garlan, R.W. *et al*. 2005. Posttraumatic Growth following the Terrorist Attacks of September 11th, 2001: Cognitive, Coping and Trauma Symptom Predictors in an Internet Convenience Sample. *Traumatology* 11(4) 247–267.

Cakir, B.O., Adamson, P. and Cingi, C. 2012. 'Epidemiology and Economic Burden of Non-melanoma Skin Cancer'. *Facial Plastic Surgery Clinics of North America*; 20(4): 419-422.

Carney, L.M. and Park, C.L. 2018. Cancer Survivors' Understanding of the Cause and Cure of their Illness: Religious and Secular Appraisal. *Journal of Psycho-Oncology* 27:1553–1558.

Carroll, M. and Campbell, L. 2008. Who now Reads Parsons and Bales: Casting a Critical Eye on the "Gendered Styles of Caregiving" Literature. *Journal of Aging Studies* 22(1):24–31.

Catz, S., Kelly, J., Bogart, L., Benotsch, E. and Mcauliffe, T. 2000. Patterns, Correlates, and Barriers to Medication Adherence among Persons Prescribed New Treatments for HIV Disease. *Journal of Health Psychology* 19:124-133.

Chapman, M.M. 1997. Pelvic Muscle Exercise/Biofeedback for Urinary Incontinence after Prostatectomy: An Education Program. *Journal of Cancer Education* 12:4, 218-223.

Chapple, A., Ziebland, S. and McPherson, A. 2004. Stigma, Shame, and Blame Experienced by Patients with Lung Cancer: Qualitative study. *British Medical Journal* 328(7454):1470.

Chipfakacha, V. 1994. The Role of Culture in Primary Healthcare. *Journal of Social and African Medicine* 84 (12): 860-861.

Clark, D. A. 2013. Cognitive Restructuring. In: S. G. Hoffman, D. J. A. Dozois, W. Rief, and J. Smits (Eds.), *The Wiley Handbook of Cognitive Behavioural Therapy* (pp. 1-22). Hoboken, NJ: John Wiley & Sons.

Clegg-Lamptey, J.N.A., Dakubo, J.C.B. and Attobra, Y.N 2009. Psychosocial Aspects of Breast Cancer Treatment in Accra, Ghana. *East African Medical Journal* 86(7):348–353.

.........., ..., ... 2009. Why Do Breast Cancer Patients Report Late or Abscond during Treatment in Ghana? A Pilot Study. *Ghana Medical Journal* 43 (3):127-131.

Cohen, S. and Wills, T.A. 1985. Stress, Social Support and the Buffering Hypothesis. *Psychological Bulletin* 98:310–357.

Compas, B. E., Worsham, N. L., Epping-Jordan, J. E. *et al*. 1994. When Mum or Dad has Cancer: Markers of Psychological Distress in Cancer Patients, Spouses, and Children. *Journal of Health Psychology* 13(6), 507–515.

Conner, M. and Norman, P. 1996. Predicting Health Behaviour Search and Practice with Social Cognition Models. Open University Press: Ballmore: Buckingham.

Cordova, M.J., Cunningham, L.L.C., Carlson, C.R. and Andrykowski, M.A. 2001. Post-traumatic Growth following Breast Cancer: A Controlled Comparison Study. *Journal of Health Psychology* 20(3):176–185.

Corey, G. 2009. Theory and practice of counselling and psychotherapy (8th ed.). Belmont, USA: Thomson Higher Education.

Costanzo, E. S., Lutgendorf, S. K., Bradley, S. L., Rose, S. L. and Anderson, B. 2005. Cancer Attributions, Distress and Health Practices among Gynecologic Cancer Survivors. *Journal of Psychosomatic Medicine* 7; 972–980.

Cousson-Gélie, F., Irachabal, S., Bruchon-Schweitzer, M., Dilhuydy, J.M. and Lakdja, F. 2005. Dimensions of Cancer Locus of Control Scale as Predictors of Psychological Adjustment and Survival in Breast Cancer Patients. *Journal of Psychological Reports* 97(3):699-711.

Cruess, D., Antoni, M., Mcgregor, B., Kilbourn, K., Boyers, A.E. *et al*. 2000. Cognitive-Behavioural Stress Management Reduces Serum Cortisol By Enhancing Benefit Finding Among Women Being Treated for Early Stage Breast Cancer. *Journal of Psychosomatic Medicine* 6; 304-8.

Crumbaugh, J. and Carr, G. 1979. Treatment of Alcoholics with Logotherapy. *The International Journal of Addictions 14*(6):847-853.

Cunningham, A.J., Lockwood, G.A. and Cunningham, J.A. 1991. A Relationship between Perceived Self-efficacy and Quality of Life in Cancer Patients. *Journal of Patient Education and Counselling* 17:71–78.

Curry, S. and Marlatt, G. A. 1987. Building Self-confidence, Self-efficacy, and Self-control. In W. M. Cox (Ed.), Treatment and Prevention of Alcohol Problems (pp. 117-138). New York: Academic Press.

Dein, S. 2004. Explanatory Models of and Attitudes towards Cancer in Different Cultures. *The Lancet Oncology* 5: 119-124.

Delaney, C., Barrere, C. and Helming, M. 2011. The Influence of a Spirituality-based Intervention on Quality of Life, Depression, and Anxiety in Community-dwelling Adults with Cardiovascular Disease: A Pilot Study. *Journal of Holistic Nursing* 29(1):21-32.

Dennison, L and Moss-Morris, R. 2010. Cognitive-behavioural Therapy: What benefits can it offer people with multiple sclerosis? *Expert Review of Neurotherapeutics* 10(9):1383-90.

Desharnais, R., Bouillon, J. and Godin, G. 1996. Self-efficacy and Outcome Expectations as Determinants of Exercise Adherence. *Psychosomatic Reports* 59:1155-1159.

DeVellis, B. M., and DeVellis, R. F. 2000. Self-efficacy and Health. In: A. Baum, T. A. Revenson, and J. E. Singer (Eds.), *Handbook of Health Psychology* 235-247. Mahwah, NJ: Erlbaum.

Diefenbach, M.A. and Leventhal, H. 1996. The Common Sense Model of Illness Representation. *Journal of Social Distress and the Homeless* 5, 11-38.

Dimitriadis, G.K., Angelousi, A., Weickert, M.O., Randeva, H.S., Kaltsas, G., *et al.* 2017. "Paraneoplastic Endocrine Syndromes" *Journal of Endocrine-Related Cancer* 24 (6): 173-190.

Dublin, R.A. 2012. Cognitive Restructuring versus Cognitive Defusion for Claustrophobic Anxiety and Avoidance. (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 3513681).

Dunigan, J., Carr, B. and Steel, J. 2007. Posttraumatic Growth, Immunity and Survival in Patients with Hepatoma. *Journal of Digestive Diseases and Sciences* 52: 2452-9.

Ebrahimi, N., Bahari, F. and Zare-Bahramabadi, M. 2014. The Effectiveness of Group Logotherapy on the Hope among the Leukemic Patients. *Iranian Journal of Cancer Prevention* 7(1): 9–16.

Edwards, B. and Clarke, V. 2004. The Psychological Impact of a Cancer Diagnosis on Families: The Influence of Family Functioning and Patients' Illness Characteristics on Depression and Anxiety. *Journal of Psycho-Oncology* 13:562-576.

Eisenbruch, M., Yeo, S.S., Meiser, B., Goldstein, D., Tucker, K. *et al*. 2004. Optimising Clinical Practice in Cancer Genetics with Cultural Competence: Lessons to be Learnt from Ethnographic Research with Chinese-Australians. *Journal of Social Science Medicine* 59:235-248.

Eke, G.K., Ugwueze, N. and Akani, N.A. 2021. Childhood Cancers in a Tertiary Centre, Southern Nigeria: Spectrum and Outcome of Treatment. *Journal of Cancer and Tumour International* 11(1):25-34.

Else Quest, N.M., LoConte, N.K., Schiller, J.H., Hyde, J.S. 2009. Perceived Stigma, Self-blame, and Adjustment among Lung, Breast and Prostate Cancer Patients. *Journal of Psychology and Health* 24(8):949-964.

Epel, E.S., McEwen, B.S. and Ickovics, J.R. 1998. Embodying Psychological Thriving: Physical Thriving in Response to Stress. *Journal of Social Issues* 54(2):301–322.

Ewart, C. K. 1992. The Role of Physical Self-efficacy in Recovery from Heart Attack. In R. Schwarzer (Ed.). Self-efficacy: Thought Control of Action (pp. 287-304). Washington, DC: Hemisphere.

Ezegbe, B.N., Ede, M., Eseadi, C., Nwaubani, O.O., *et al*. 2018. Effect of Music Therapy Combined with Cognitive Restructuring Therapy on Emotional Distress in a Sample of Nigerian Married Couples. *Journal of Medicine* 97 (34).

Ezeome, E.R. and Anarado, A.N. 2007. Use of Complementary and Alternative Medicine by Cancer Patients at the University of Nigeria Teaching Hospital, Enugu, Nigeria. *Journal of Medicine* 7:28.

Fabry, J.B. 1987. The Pursuit of Meaning (Revised eds.). Berkeley, CA: Institute of Logotherapy Press.

Fairbrother, N., 2011. Social Support. *Issue of Visions Journal* 6(4):7.

Faller, H., Schilling, S. and Lang, H. 1995. Causal Attribution and Adaptation among Lung Cancer Patients. *Journal of Psychosomatic Research* 39:619–627.

Fapohunda, A., Fakolade, A., Omiye, J., Afolaranmi, O., Arowojolu, O. *et al*. 2020. Cancer Presentation Patterns in Lagos, Nigeria: Experience from a Private Cancer Cente. *Journal of Public Health in Africa* 11:1138; 98-104.

Ferlay, J., Ervik, M., Lam, F., Colombet, M., Mery, L. *et al*. 2020. Global Cancer Observatory: Cancer Today. Lyon: International Agency for Research on Cancer; 2020 (https://gco.iarc.fr/today, accessed February 2021).

Ferrucci, L. M., Cartmel, B., Turkman, Y. E., Murphy, M. E., Smith, T. *et al*. 2011. Causal Attribution among Cancer Survivors of the Ten Most Common Cancers. *Journal of Psycho-Oncology* 9 (2): 121-140.

Figueiredo, M.I., Fries, E. and Ingram, K.M. 2004. The Role of Disclosure Patterns and Unsupportive Social Interactions in the Well-Being of Breast Cancer Patients. *Journal of Psycho-Oncology* 13(2):96-105.

Fillion, L., Duval, S., Dumont, S., Gagnon, P., Tremblay, I. *et al*. 2009. Impact of a Meaning-centered Intervention on Job Satisfaction and on Quality of Life among Palliative Care Nurses. *Journal of Psycho-Oncology* 18(12):1300-1310.

Fong, A.J., Scarapicchia, T.M., McDonough, M.H., Wrosch, C., Sabiston, C.M. 2017. Changes in Social Support Predict Emotional Well-being in Breast Cancer Survivors. *Journal of Psycho-Oncology* (5):664–671.

Foster, C. and Fenlon, D. 2011. Recovery and Self-management Support following Primary Cancer Treatment. *British Journal of Cancer* 105:21-28.

Foster, C., Breckons, M., Cotterell, P., Barbosa, D., Calman, L., *et al*. 2014. Cancer Survivors' Self-efficacy to Self-manage in the Year following Primary Treatment. *Journal of Cancer Survivorship:Research and Practice* 9:10.

Frankl, V. 2006. *Man's Search for Meaning. An Introduction to Logotherapy.* Boston, MA: Beacon Press.

………. 1969. The Will to Meaning: Foundations and Applications of Logotherapy. New York: New American Library.

………. 1978. The Unheard Cry for Meaning. New York: Simon and Schuster.

………. 1992. Man's Search for Meaning: An Introduction to Logotherapy. Boston: Beacon Press. (Original work published 1963.)

………. 1997. Viktor Frankl—Recollections: An Autobiography. New York: Plenum.

………. 1959. Man's Search for Meaning. New York: Random House.

………. 1984. Man's Search for Meaning. New York: Touchstone. Simon and Schuster.

………. 1985. Man's Search for Meaning: Simon and Schuster; .[https:// www. bookdepository.com/Mans-Search-for-Meaning-Viktor EFrankl/9780671244224]

Frazier, P., Tashiro, T., Berman, M., Steger, M. and Long. J. 2004. Correlates of Levels and Patterns of Posttraumatic Growth among Sexual Assault Survivors. *Journal of Consulting and Clinical Psychology* 72:19-30.

Freitas, A.G. and Weller, M. 2015. Patient Delays and System Delays in Breast Cancer Treatment in Developed and Developing Countries. *Cien Saude Colet* (10):3177-89.

Funch, D. P. and Mettlin, C. 1982. The Role of Support in Relation to Recovery from Breast Surgery. *Journal of Social Science and Medicine* 16:91–98.

Furnham, A., Akande, D. and Baguma, P. 1999. Beliefs about Health and Illness in Three Countries: Britain, South Africa and Uganda. *Journal of Psychology, Health and Medicine* 4(2):189-201.

Gall, T.L. 2003. Religious and Spiritual Attributions in Older Adults' Adjustment to Illness. *Journal of Psychology and Christianity* 22(3):210-222.

Gallagher, E.J. and LeRoith, D. 2015. Obesity and Diabetes: The Increased Risk of Cancer and Cancer-Related Mortality. *Journal of Physiological Review* 95(3):727-748.

Galloway, S., Graydon, J., Harrison, D., Evans-Boyden, B., Palmer-Wickham, S., *et al*. 1999. Informational Needs of Women with a Recent Diagnosis of Breast Cancer. Development and Initial Testing of a Tool. *Journal of Advanced Nursing* 25(6), 1175-1183.

Gelman, M. and Gallo, J. 2009. Finding Meaning in Life at Midlife and Beyond: Wisdom and Spirit from Logotherapy. *Journal of Judaism and Civilization* 8(59):91-93.

Giese-Davis, J., Koopman, C,, Butler, L.D., Classen, C., Morrow, G.R., *et al*. 1999. Self-efficacy with Emotions Predicts High Quality of Life in Primary Breast Cancer Patients. Self-efficacy and Cancer: Theory, Assessment, and Treatment;

Symposium Conducted at the Meeting of the Society of Behavioural Medicine; San Diego; Brady, M. (chair).

Gil, P.J.M., Carrillo, F.X.M. and Meca, J.S. 2001. Effectiveness of Cognitive-behavioural Treatment in Social Phobia: A Meta-analytic Review. *Journal of Psychology* 5:17-25.

Gilbar, O. 2005. Breast Cancer: How do Israeli Women Cope? A Cross-sectional Sample. *Journal of Families, Systems, and Health* 23(2): 161–171.

Glanz, K., Rimer, B. and Viswanath, K. 2008. Health Behaviour and Health Education: Theory, Research, and Practice. 4th Edition, Jossey-Bass, San Francisco.

Glanz, K., Rimer, B. K. and Lewis, F. M. 2002. Health Behaviour and Health Education: Theory, Research and Practice: San Fransisco: Wiley and Sons.

Global Burden of Disease, 2016. Risk Factors Collaborators. Global, Regional, and National Comparative Risk Assessment of 84 Behavioural, Environmental, Occupational, and Metabolic Risks or Clusters of Risks, 1990–2016: GBD results tool. Seattle (WA): Institute for Health Metrics, University of Washington.

Goldinger, S. D., Kleider, H. M., Azuma, T. and Beike, D. R. 2003. "Blaming The Victim" Under Memory Load. *Journal of Psychological Sciences* 14(1), 81–85.

Gómez-de-Regil,L. 2014. Causal Attribution and Illness Perception: A Cross-Sectional Study in Mexican Patients with Psychosis; *The Scientific World Journal* 969867. 10.1155/2014/969867.

Gorman, L. M. 2018. The Psychosocial Impact of Cancer on the Individual, Family and Society. In Bush, N. J., Gorman, L. M. and Oncology Nursing Society, *Psychosocial Nursing Care along the Cancer Continuum*. Pittsburgh, Pa: Oncology Nursing Society.

Graham H. 1983. Caring: A Labour of Love. In: Finch J., Groves D., Editors. A Labour of Love: Women, Work and Caring: Routledge and Kegan Paul; London.

Gregg, J. and Curry, R. H. 1994. Explanatory Models for Cancer among African-American Women at Two Atlanta Neighbourhood Health Centers: The Implications for a Cancer Screening Program. *Journal of Social Science and Medicine* 39(4):519–526.

Gruder, C.L., Mermelstein, R.J., Kirkendol, S., Hedeker, D.,Wong, S.C., *et al.* 1993. Effects of Social Support and Relapse Prevention Training as Adjuncts to a Televised Smoking-cessation Intervention. *Journal of Consulting and Clinical Psychology* 61:113-120.

Gudjonsson, G.H. and Singh, K.K. 1989. The Revised Gudjonsson Blame Attribution Inventory. *Journal of Personality and Individual Differences* 10(1):67-70.

Gurung, R.A.R. 2006. Health Psychology: A Cultural Approach. Belmont CA: Thomson Wadsworth.

Guttmann, D., 1996. Logotherapy for the Helping Professional: Meaningful Social Work. New York: Springer.

Haaga, D.A.F. and Stewart, B. L. 1992. Self-efficacy for Recovery from a Lapse after Smoking Cessation. *Journal of Consulting and Clinical Psychology* 60:24-28.

Hagger, M.S. 2019. The Reasoned Action Approach and the Theories of Reasoned Action and Planned Behaviour. In D. S. Dunn (Ed.), Oxford Bibliographies in Psychology. New York, NY: Oxford University Press. doi: 10.1093/OBO/9780199828340-0240.

Hajibabaei, M., Kajbaf, M.B., Esmaeili, M., Harirchian, M.H. and Montazeri, A. 2020. Impact of an Existential-Spiritual Intervention Compared with a Cognitive-Behavioural Therapy on Quality of Life and Meaning in Life among Women with Multiple Sclerosis. *Iranian Journal of Psychiatry* 15(4):322-330.

Halford, W.K., Scott, J.L. and Smythe, J. 2000. Couples and Coping with Cancer: Helping each other through the night. In K.B. Schmaling and T.G. Sher (Eds.), The Psychology of Couples and Illness: Theory, Research and Practice (pp. 135-170). Washington, DC: American Psychological Association. Family Development in the Face of Cancer.

Hamid, N., Talebian, L., Mehrabizadeh-Honarmand, M. and Yavari, A. 2011. The Effects of Logotherapy on Depression, Anxiety and Quality of Life of Cancer Patients in Ahvaz Big Oil Haspital. *Journal of Psychological Achievements* 18(2):199-224.

Harvey, J. H. and Weary, G. W. 1981. Perspectives on Attributional Processes. Dubuque, I.A: Wm. C. Brown.

Harvey, P. and Martinko, M. 2009. An Empirical Examination of the Role of Attributions in Psychological Entitlement and its Outcomes. *Journal of Organizational Behaviour* 30:459 - 476.

Hassani, F., Emamipour. S. and Mirzaei, H. 2018. Effect of Acceptance and Commitment Group Therapy on Quality of Life and Resilience of Women With Breast Cancer. *Archives of Breast Cancer* 6:111-7.

Hatt, H. 1965. Existential Analysis and Logotherapy: The Contribution of Viktor E Frankl. *Encounter* 26(3):330-339.

Heider, F. 1958. The Psychology of Interpersonal Relations. John Wiley and Sons Inc.

Helgeson, V.S. and Cohen, S. 1996. Social Support and Adjustment to Cancer: Reconciling Descriptive, Correlational and Intervention Research. *Journal of Health Psychology* 15:135–148.

Helgeson, V.S., Reynolds, K.A. and Tomich, P.L. 2006. A Meta-analytic Review of Benefit Finding and Growth. *Journal of Consulting and Clinical Psychology* 74(5):797–816.

Helman, C.G. 1994. Culture, Health and Illness. An Introduction for Health Professionals (3rd ed.). London: Butterworth-Heinemann.

Helman, C.G. 2001. Culture, Health and Illness. London: Arnold.

Hillmann, M. 2004. Viktor E. Frankl's Existential Analysis and Logotherapy. New York: Wiley.

Hirschman, K. and Bourjolly, J. 2005. How do Tangible Supports Impact the Breast Cancer Experience? *Journal of Social Work in Health Care* 41:17-32.

Hochbaum, G., Rosenstock, I. and Kegels, S. 1952. Health Belief Model. United States Public Health Service.

Hochlaf, D., Quilter-Pinner, H. and Kibasi, T. 2019. Ending the Blame Game. The Case for a New Approach to Public Health and Prevention. Institute for Public Policy Research.

Hoffman, A. J., Brintnall, B. A., Brown, J. K., Ige, A., Jones, L. W., *et al.* 2013. Too Sick not to Exercise: Using a 6 Week, Home-Based Exercise Intervention for Cancer-related Fatigue, Self-management for Post surgical Small Cell Lung Cancer Patients. *Journal of Cancer Nursing* 36(3):175-188.

Holland, K. and Holahan, C. 2003. The Relation of Social Support and Coping to Positive Adaptation to Breast Cancer. *Journal of Psychology and Health* 18:15-29.

Holman, H. R. and Lorig, K. 1992. Perceived Self-efficacy in Self-management of Chronic Disease. In R. Schwarzer (Ed.), Self-efficacy:Thought Control of Action (pp. 305-323). Washington, DC: Hemisphere.

Horne, R. 2006. Compliance, Adherence and Corcordance: Implications for Asthma Treatment. *Chest* 130(1):65-72.

Hoskins, C. N., Baker, S., Sherman, D., Bohlander, J., Bookbinder, M. *et al*. 1996. Social Support and Patterns of Adjustment to Breast Cancer. *Scholarly Inquiry for Nursing Practice* 10(2), 99-123.

Hosseinigolafshani, S.Z., Taheri, S., Mafi, M., Mafi, M.H., Kasirlou, L. 2020. The Effect of Group Logotherapy on the Burden of Hemodialysis Patients' Caregivers. *Journal of Renal Injury Prevention* 9(4):e33.

Iddrisu, M., Aziato, L. and Dedey, F. 2020. Psychological and Physical Effects of Breast Cancer Diagnosis and Treatment on Young Ghanaian Women: A Qualitative Study. *Journal of Psychiatry* 20:353.

Imran, O., Morhason-Bello, I.O., Kareem, Y.O. and Adewole, I.F. 2020. Modelling for Predictors of Knowledge Score on Etiology and Prevention Strategies for Cervical Cancer among Women of Reproductive Age in Ibadan. *Journal of Global Oncology* 6:892-903.

Institute of Health Metrics and Evaluation, 2016 (Global Burden of Disease Study-Cancer Incidence, Mortality, Years of Life Lost, Years Lived with Disability, and Disability-Adjusted Life Years 1990-2016).

International Agency for Research on Cancer (IARC), 2013. World Cancer Statistics. WHO Press Release: 223:1-3

.... 2016. Global Initiative for Cancer Registry Development. Lyon: France.

Isa-Modibbo, F., Dareng, E., Bamisaye, P. *et al*. 2016. Qualitative Study of Barriers to Cervical Cancer Screening among Nigerian Women. *British Medical Journal* 11:6(1):e008533.

Ishola, F. and Omole, O. 2016. A Vision for Improved Cancer Screening in Nigeria. *The Lancet* 4:e359-60.

Jaarsma, T.A., Pool, G., Ranchor, A.V. and Sanderman, R. 2007. The Concept and Measurement of Meaning in Life in Dutch Cancer Patients. *Journal of Psychooncology* 16(3):241-248.

Jafari- Koulaee, A., Khenarinezhad, F., Abutalebi, M. and Bagheri-Nesami, M. 2018. The Effect of Logotherapy on Depression in Cancer Patients: A Systematic Review Study. *World Cancer Research Journal* 5(3):23-9.

Jamali, F. 2002. The Study of the Relationship between Religious Attitudes and Mental Health of the University of Tehran Students. Unpublished Master thesis. Tehran: Al-Zahra University.

Janz, N. K. and Becker, M. H. 1984. The Health Belief Model: A Decade Later. *Health Education Quarterly* 11:1-47.

Jegede, A.S. 2002. The Yoruba Cultural Construction of Health and Illness. *Nordic Journal of African Studies* 11(3):322-335.

Jenkins, R.A. and Pargament, K.I. 1988. Cognitive Appraisals in Cancer Patients. *Journal of Social Science Medicine* 26(6):625-633.

Jones, E. E. and K. E. Davis. 1965. From Acts to Dispositions: The Attribution Process in Person Perception. In L. Berkowitz ed. Advances in Exploring Social Psychology (Vol.2), pp. 219-266. Academic Press.

Kagawa-Singer, M. 2000. A Socio-cultural Perspective on Cancer Control Issues for Asian Americans. *Asian-American Pacific Journal of Health* 8(1):12–17.

Kang, K., Shim, J., Jeon, D. and Koh, M. 2009. The Effects of Logotherapy on Meaning in Life and Quality of Life of Late Adolescents with Terminal Cancer. *Journal of Korean Academy in Nursing* 39(6):759-768.

Kantor, D. 2016. Psychological Distress. In Kantor, D. and Suzan, Z. (eds.). *Issues of Cancer Survivorship: An Interdisciplinary Team Approach to Care.* Philadelphia, PA: Wolters Kluwer: 47–63.

Kaplan, R.M., Atkins, C.J. and Reinsch, S. 1984. Specific Efficacy Expectations Mediate Exercise Compliance in Patients with COPD. *Journal of Health Psychology* 3:223-242.

Kardinal, C. and Yarbro, J.A. 1979. Conceptual History of Cancer. *Seminar in Oncology* 6:396-408.

Kelley, H.H. 1967. Attribution Theory in Social Psychology. In D. Levine (Ed.), Nebraska Symposium on Motivation (Vol. 15, pp. 192-238). Lincoln:University of Nebraska Press.

Kelley, H.H. and Michela, J.L. 1980. Attribution Theory and Research.

Kelley, H.H. 1973. The Processes of Causal Attribution. *Journal of American Psychiatry* 28:107-128.

Kelly, E.P., Tsilimigras, D.I., Hyer, J.M. and Pawlik, T.M. 2019. Understanding the Use of Attachment Theory Applied to the Patient-provider Relationship in Cancer Care: Recommendations for Future Research and Clinical Practice. *Journal of Surgical Oncology* 101-110.

Kendra, C. 2016. Attribution and Social Psychology. verywellmind.com. Retrieved 10th March, 2018.

Khalili, N, Farajzadegan, Z, Mokarian, F. and Bahrami, F. 2013."Coping Strategies, Quality of Life and Pain in Women with Breast Cancer. *Iranian Journal of Nursing and Midwifery Research* 18(2):105–111.

Kim, H., Sherman, D. and Taylor, S. 2008. Culture and Social Support. *The American Psychologist* 63:518-526.

Kim, J., Han, J.Y., Shaw, B., McTavish, F., Gustafson, D. 2010. The Roles of Social Support and Coping Strategies in Predicting Breast Cancer Patients' Emotional Well-being: Testing Mediation and Moderation Models. *Journal of Health Psychology* (4):543–552.

Kishore, J., Ahmad, I., Kaur, R. and Mohanta, P.K. 2008. Beliefs and Perceptions about Cancers among Patients attending Radiotherapy Out-Patient Department in Delhi, India. *Asian Pacific Journal of Cancer Prevention* 9(1):155–8.

Knapp, P. and Beck, A. 2008. Cognitive Therapy Foundations, Conceptual Models, Applications, Research. Revista brasileira de psiquiatria (São Paulo, Brazil : 1999). 30 (2) 54-64.

Koehly, L.M., Peterson, S.K., Watts, B.G., Kempf, K.K., Vernon, S.W. *et al.* 2003. A Social Network Analysis of Communication about HNPCC Genetic Testing and Family Functioning. *Journal of Cancer Epidemiology, Biomarkers and Prevention* 12: 304-313.

Koopman, C., Hermanson, K.S., Diamond, S., Angell, K. and Spiegel, D. 1998. Social Support, Life Stress, Pain and Emotional Adjustment to Advanced Breast Cancer. *Journal of Psycho-Oncology* 7(2):101-11.

Kulik, L. and Kronfeld, M. 2005. Adjustment to Breast Cancer: The Contribution of Resources and Causal Attributions Regarding the Illness. *Journal of Social Work in Health Care* 41(2):37-57.

Kushi L.H., Doyle C. and McCullough M. 2012. American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention: Reducing the Risk of Cancer with Healthy Food Choices and Physical Activity. *Journal of Clinical Psychology* 62 (1): 30–67.

Lachman, M. E., Weaver, S. L., Bandura, M., Elliott, E., and Lewkowicz, C. J. 1992. Improving Memory and Control Beliefs through Cognitive Restructuring and Self-generated Strategies. *Journal of Gerontology* 47:293-299.

Lam, L. 2019. "Promoting Self-Efficacy among Head and Neck Cancer Patients". Doctoral Projects. 122. DO.I: https://do.i.org/10.31979/etd.g4hb-85e2.

La-Morte, W.W., 2018. Behavioural Change Models. Boston University School of Public Health.

Landrine, H. and Klonoff, E.A. 1992. Culture and Health–related Schemas: A Review and Proposal for Interdisciplinary Integration. *Journal of Health Psychology* 11: 267-276.

Landrine, H. and Klonoff, E.A. 1994. Cultural Diversity in Causal Attributions for Illness:The Role of the Supernatural. *Journal of Behavioural Medicine* 17:181-193.

Langford, C.P.H., Bowsher, J., Maloney, J.P. and Lillis, P.P. 1997. Social support: A Conceptual Analysis. *Journal of Advanced Nursing* 25:95-100.

Lazarus, R.S. and Folkman, S. 1984. Stress, Appraisal and Coping. New York: Springer.

.........., ... 1987. Transactional Theory and Research on Emotions and Coping. *European Journal of Personality* 1:141-170.

Lee, S.Y., Hwang, H., Hawkins, R. and Pingree, S. 2008. Interplay of Negative Emotion and Health Self-efficacy on the use of Health Information and its Outcomes. *Journal of Communication Research* 35(2):358-381.

Lepore, S. J. and Helgeson, V. S. 2012**.** Social Constraints, Intrusive Thoughts and Mental Health after Prostate Cancer. *Journal of Social and Clinical Psychology* 17(1):89-106

Lev, E., Eller L.S., Kolassa, J., Gejerman, G., Colella, J., *et al.* 2007. Exploratory Factor Analysis: Strategies used by Patients to Promote Health. *World Journal of Urology* 25:87–95.

Lichtman, R.R.,Taylor, S.E. and Wood, J.V. 1988. Social Support and Marital Adjustment after Breast Cancer. *Journal of Psycho-Onc*ology 3:47–74.

Linde, J.A., Rothman, A.J., Baldwin, A.S., Jeffery, R.W. 2006. The Impact of Self-efficacy on Behaviour Change and Weight Change among Overweight Participants in a Weight Loss Trial. *Journal of Health Psychology* 25(3):282-329.

Linley, P. A., Joseph, S., and Goodfellow, B. 2008. Positive Changes in Outlook following Trauma and their Relationship to Subsequent Posttraumatic Stress,

Depression and Anxiety. *Journal of Social and Clinical Psychology* 27(8):877–891.

Linley, P.A. and Joseph, S. 2004. Positive Change Processes following Trauma and Adversity: A Review. *Journal of Traumatic Stress* 17:11–22.

Litt, M. D. 1988. Self-efficacy and Perceived Control: Cognitive Mediators of Pain Tolerance. *Journal of Personality and Social Psychology 54*:149-160.

Lukas, E. 1984. Meaningful Living. Berkeley, CA: Institute of Logotherapy Press.

Luszczynska, A. and Schwarzer, R. 2003. Planning and Self-efficacy in the Adoption and Maintenance of Breast Self-examination: A Longitudinal Study on Self-Regulatory Cognitions. *Journal of Psychology and Health* 18:93-108.

Macmillan, D.H. 2010. Cancer Support and National Health Service Improvement. National Cancer Survivorship Initiative Vision. 2010.http://www.n.csi.org.uk/wp-content/uploads/N.CSI-Vision-Document.pdf.

Madge, C. 1998. Illness and Culture. In Vaughn, L.M., Psychology and Culture: Thinking, Feeling and Behaving in a Global Context: Psychology Focus

Maiback, E. and Murphy, D.A. 1995. Self-efficacy in Health Promotion Research and Practice: Conceptualization and Measurement. *Journal of Health Education Research* 10(1):37-50.

Majaj, L., Nassar, M. and De-Allegri, M. 2013. "It's not Easy to Acknowledge That I'm Ill": A Qualitative Investigation into the Health Seeking Behavioiur of Rural Palestinian Women. *BMC Women's Health* 24:13:26.

Maly, R. C., Umezawa, Y., Leake, B., and Silliman, R. A. 2005. Mental Health Outcomes in Older Women with Breast Cancer: Impact of Perceived Family Support and Adjustment. *Journal of Psycho-Oncology* 14(7):535–545.

Mantler, J., Schellenberg, E.G. and Page, J.S. 2003, Attributions for Serious Illness: Are Controllability, Responsibility, and Blame Different Constructs? *Cancer Journal in Behavioural Science* 35(2):142-152.

Mao, W. and Gratch, J. 2005. Social Causality and Responsibility: Modelling and Evaluation. *Fifth International Conference on Interactive Virtual Agents*.

Mao, W. 2006. Modeling Social Causality and Social Judgement in Multi-Agent Interactions. Doctoral Dissertation, University of Southern California, Los Angeles, California.

Mardanivalendani, M. and Ghafari, Z. 2015. The Effectiveness of Logotherapy on Quality of Life among Multiple Sclerosis Patients in Shahrekord. *Journal of Ilam University of Medical Sciences* 23(5):47-56.

Maree, J. and Mulonda, J. 2015. "My experience has been a terrible one, something I could not run away from": Zambian Women's Experiences of Advanced Breast Cancer. *International Journal of Africa Nursing Sciences* 3:10.

Marlatt, G. A. and Gordon, J. R. (Eds.). 1985. Relapse Prevention. New York: Guilford.

Marlatt, G. A., Baer, J. S. and Quigley, L. A. 1994. Self-efficacy and Addictive Behaviour. In A. Bandura (Ed.). Self-efficacy in Changing Societies. Marbach, Germany: Johann Jacobs Foundation.

McCormick-Brown K. J. 1999. Health Belief Model. Barlett Publishing Editor.

McCutchan, G., Weiss, B., Quinn- Scoggins, H., *et al*. 2021. Psychosocial Influences on Help- seeking Behaviour for Cancer in Low- income and Lower Middle-income Countries: A Mixed-methods Systematic Review. *Journal of Global Health* 6:e004213.

McGuire, S., 2015. World Cancer Report 2014. Geneva, Switzerland: World Health Organization, International Agency for Research on Cancer, WHO Press.

McLeod, J. and McLeod, J. 2011. Counselling Skills: A Practical Guide for Counsellors and Helping Professionals (2nd ed.) Berkshire, England: McGraw-Hill, Open University Press.

McLeod, S. A. 2015. Skinner Operant Conditioning. Retrieved from Google Scholar

Mdondolo, N., De-Villiers, L. and Ehlers, V.J. 2004. Cultural Factors Associated with Management of Breast Lumps amongst Xhosa Women: Research. *Health South Africa Gesondheid* 8(3):86–97.

Mehrangiz, S.H., Mehravar, M.J., Fariba, E.T. and Shirin, K. 2012. The Effect of Logotherapy on Improving the Quality of Life in Girl Students with Post Traumatic Stress Disorder. *Life Scientific Journal* 9(4):5692-5698.

Merluzzi, T.V.and Nairn, R.C. 1999. An Exploration of Self-efficacy and Longevity in Persons with Cancer. Self-efficacy and Cancer: Theory, Assessment, and Treatment; Symposium Conducted at the Meeting of the Society of Behavioural Medicine; San Diego. March 1999; Brady, M. (chair).

Meyerowitz, B. E. and Chaiken, S. 1987. The Effect of Message Framing on Breast Self-examination, Attitudes, Intentions and Behaviour. *Journal of Personality and Social Psychology* 52:500-510.

Milam, J.E. 2004. Posttraumatic Growth among HIV/AIDS Patients. *Journal of Applied and Social Psychology* 34(11):2353-2376.

Miller, S. M., Rodoletz, M., Schoreder, C. M., Mangan, C. E. and Sedlacek, T. V. 1998. Applications of the Monitoring Process Model to Coping with Severe Long-term Medical Threats. *Journal of Health Psychology* 15(3):216-225.

Mohabbat-Bahar, S., Golzari, M., Moradi-Joo, M. and Akbari, M.E. 2014. Efficacy of Group Logotherapy on Decreasing Anxiety in Women with Breast Cancer. *Iranian Journal of Cancer Prevention* 7(3):165-70.

Molassiotis, A., Lopez, V., Chung, W., Lam, S., Li, P., *et al*. 2002. Factors Associated with Adherence to Antiretroviral Medication in HIV-infected Patients. *International Journal of STD and AIDS* 13: 301-310.

Moorey, S., Cort, E., Kapari, M., Monroe, B., Hansford, P. *et al*. 2009. A Cluster Randomized Controlled Trial of Cognitive Behaviour Therapy for Common Mental Disorders in Patients with Advanced Cancer. *Journal of Psychology and Medicine* 39(5):713-723.

Moos, R. H. and Holahan, C. J. 2007. Adaptive Tasks and Methods of Coping with Illness and Disability. In E. Matz and H. Lirneh (eds), Coping with Chronic Illness and Disability. (pp. 107-128). New York: Springer.

Moses, V. 2021. A Non-randomized Study Investigating the Effectiveness of Cognitive Reframing in Socially Disconnected Widows. *European Research Journal* 7(1):1-11.

Muhamad, M., Afshari, M. and Kazilan, F. 2011. Family Support in Cancer Survivorship. *Asian Pacific Journal of Cancer Prevention* 12:1389-1397.

Mui, A. C. and Morrow-Howell, N. 1993. Sources of Emotional Strain among the Oldest Caregivers. *Journal of Research on Aging* 15:50-69.

Mulatu, M.S. 2000. Perceptions of Mental and Physical Illness in North-western Ethiopia: Causes, Treatments and Attitudes. *Journal of Health Psychology* 4:531-549.

Multon, K.D., Brown, S.D., and Lent, R.W. 1991. Relation of Self-efficacy Beliefs to Academic Outcomes: A Meta-analytic Investigation. *Journal of Counselling Psychology* 38:30-38.

Murguía, A., Peterson, R.A. and Zea, C.A. 2003. Use and Implications of Ethnomedical Health Care Approaches among Central American Immigrants, *Journal of Health and Social Work* 28:(1):43–51.

Murphy, D.,Greenwell, L., and Hoffman, D. 2002. Factors Associated with Antiretroviral Adherence among HIV-Infected Women with Children. *Journal of Women and Health* 36:97-111.

Nader, M., Ghanbari, N., Tajabadi-pour, S., Gholipour, S., Esmaeilzadeh, N. 2019. Effectiveness of Short-term Group Logo-therapy on Life Expectancy and Resilience of Women With Breast Cancer. *Archives of Breast Cancer* 6(4):168-173.

National Cancer Institute, 2014. Factsheets on Cancer. U.S Department of Health and Human Services.

.... 2018. Factsheet. U.S Department of Health and Human Services.

Nausheen, B., Gidron, Y., Peveler, R. and Moss-Morris, R. 2009. Social support and Cancer Progression: A Systematic Review. *Journal of Psychosomatic Research* 67(5):403–415.

Neuling, S.J. and Winefield, H.R. 1998. Social Support and Recovery after Surgery for Breast Cancer: Frequency and Correlates of Supportive Behaviours by Family, Friends and Surgeon. *Journal of Social Science and Medicine* 7:385–390.

Nezu, A. M., Greenberg, L. M., and Nezu, C. M. 2010. Psychooncology. In I. B. Weiner and W. E. Craighead (Eds.), The Corsini Encyclopedia of Psychology (4th ed., pp. 1354–1355).Hoboken, NJ: Wiley.

Nicolucci, A., Kovacs-Burns, K., Holt, R.I.G., Comaschi, M., Hermanns, N. *et al*. 2013. Diabetes Attitudes, Wishes and Needs. Second Study:Cross-national Benchmarking of Diabetes-related Psychosocial Outcomes for People with Diabetes. *Research: Educational and Psychological Issues:* Diabetic Medicine DOI:10.1111/dme.12245

Nigerian National System of Cancer Registries (NSCR). 2012. In brief: Cancer Incidence in Nigeria. Globocan;4(1):1-10.

Northouse, L. 1989. A Longitudinal Study of the Adjustment of Patients and Husbands to Breast Cancer. *Oncology Nursing Forum* 16(4):511-516.

Northouse, L., Mood, D., Templin, T. and Mellon, S. 2000. Couples' Patterns of Adjustment to Colon Cancer. *Journal of Social Science and Medicine* 6:271–284.

Northouse, L., Templin, T. and Mood, D. 2001. Couples' Adjustment to Breast Disease During the First Year Following Diagnosis. *Journal of Behavioural Medicine* 24: 115–136.

Nathan, P. E. and Gorman, J. M. 2002. A Guide to Treatments that Work (2nd ed.). New York, NY, US: Oxford University Press.

Odebiyi, A.I. 1980. Socio-economic Status, Illness Behaviour and Attitudes towards Disease Aetiology in Ibadan. *Nigeria Behavioural Science Journal* 3*:*172-186.

Ofole, M. and Omole, O. 2017. Remedial Effect of Cognitive Reframing and Self-Acceptance Therapy on Enhancement of Optimism among Students Diagnosed with Learned Helplessness in Ibadan Metropolis. ResearchGate

Ogunkorode, A., Holtslander, L., Ferguson, L., Maree, J.E., Anonson, J. *et al.* 2021. Factors Influencing the Health-seeking Behaviours of Women with Advanced Stages of Breast Cancer in Southwestern Nigeria: An Interpretive Description Study. *International Journal of Africa Nursing Sciences* 14:100273.

Oke, E.A. 1995. Traditional Health Services: An Investigation of Providers and the Level and Pattern of Utilization among the Yoruba. *Ibadan Social Service* 1:2-5.

Okobia, M.N, Bunker, C.H. and Okonofua, F.E., *et al.* 2006. Knowledge, Attitude and Practice of Nigerian Women towards Breast Cancer: A Cross-sectional Study. *World Journal of Surgical Oncology* 4:11.

Oladeji, A., Atalabi, O., Jimoh, M, *et al*. 2017. Delay in Presentation of Cancer Patients for Diagnosis and Management: An Institutional Report. *International Journal of Oncology* 13:1.

Olasoji, H.O., Ahmad, B., Ligali, T. and Yahaya, A. 2011. Explanatory Models of and Attitudes towards Oral Cancer in Two Nigerian Ethnic Groups: Implications in Treatment and Preventive Programme. *Pakistan Oral and Dental Journal* 28(1):17–24.

O'Leary, A., Shoor, S., Lorig, K. and Holman, H. R. 1988. A Cognitive-Behavioural Treatment for Rheumatoid Arthritis. *Journal of Health Psychology* 7:527-542.

Ololade, K., Alabi, A., Fadipe, B. and Adegboyega, B. 2019. The 'Evil Arrow' Myths and Misconceptions of Cancer at Lagos University Teaching Hospital, Nigeria. *South African Journal of Oncology* 3:10.4102/sajo.v3i0.49.

Omonzejele, P.F. 2008. African Concepts of Health, Disease and Treatment: An Ethical Enquiry. Explore (NY) 4(2):120–125.

Opoku, S.Y., Benwell, M. and Yarney, J. 2012. Knowledge, Attitudes, Beliefs, Behaviour and Breast Cancer Screening Practices in Ghana. *West Africa Pan African Medical Journal* 11:28.

Osime, C. O. and Dongo, A. E. 2002. Presentation Pattern and Outcome of Breast Cancer in a Poor Economy: A Definition of the Tripod of Ignorance, Disease and Poverty. *Ebonyi Medical Journal* 11:1-2.

Pajares, F. 1996. Current Directions in Self-efficacy Research. In M. L. Maehr and P. R. Pintrich (Eds.), Advances in Motivation and Achievement (Vol. 10, pp. 1-49). Greenwich: JAI Press.

Pandey, S. and Vajpeyi, L. 2020. Clinical Interview: Improving Quality of Life in Cancer Patients. *UGC Care Journal* 31(4):681-701.

Papavramidou, N., Paparamidis T. and Demetriou, T. 2010. Ancient Greek and Greco-Roman Methods in Modern Surgical Treatment of Cancer. *Journal of Annual Surgical Oncology* 17:665-667.

Parkin, D.M., Boyd, L., Walker, L.C. 2011. "The Fraction of Cancer Attributable to Lifestyle and Environmental Factors in the UK in 2010". *British Journal of Cancer* 105 (2): 77–81.

Pearlin, L.I. and Skaff, M.M. 1996. Stress and the Life Course: A Paradigmatic Alliance

Pellebon, D. and Anderson, S. 1999. Understanding the Life Issues of Spiritually Based Clients Families in Society: *The Journal of Contemporary Human Services* 229-238.

Pennebaker, J. W. 2011. The Secret Life of Pronouns: What our Words Say about us. Bloomsbury Press.

Peters-Golden H. 1982. Breast Cancer:Varied Perceptions of Social Support in the Illness Experience. *Journal of Social Science Medicine* 16:482–491.

Peterson, C. and Seligman, M.E.P. 2003. Character Strengths before and after September 11. *Journal of Psychological Science* 14:381-384.

Peterson, C., Seligman, M. E. P., Yurko, K. H., Martin, L. R. and Friedman, H.S. 1998. Catastrophizing and Untimely Death. *Journal of Psychological Science* 9(2): 127–130.

Pistrang, N. and Barker, C. 2002. Psychotherapy and Social Support: Integrating Research on Psychological Helping. *Clinical Psychology Review* 22:361-379.

Ponsaran, A.G. 2007. The Philosophical Foundations of Viktor Frankl's Logotherapy. *Philippiniana Sacra* 42(125):339-354.

Powe, B. 1995. Perceptions of Cancer Fatalism among African Americans. *Journal of National Black Nurses Association* 7:41-48.

Primomo, J., Yates, B.C. and Woods, N.F. 1990. Social Support for Women during Chronic Illness: The Relationship among Sources and Types to Adjustment. *Journal of Research in Nursing and Health* 13 (3):153-161.

Prochaska, J.O., Norcross, J.C., Fowler, J., Follick, M.J. and Abrams, D.B. 1992. Attendance and Outcome in a Worksite Weight Control Program: Processes and Stages of Change as Process and Predictor Variables. *Addictive Behaviour* 17: 35-45.

Pruitt L, Mumuni T, Raikhel E, *et al*. 2015. Social Barriers to Diagnosis and Treatment of Breast Cancer in Patients Presenting at a Teaching Hospital in Ibadan, Nigeria. *Journal of Global Public Health* 10:331-44.

Pytell, T. 2003. Redeeming the Unredeemable: Auschwitz and Man's Search for Meaning. *Holocaust and Genocide Studies* 17:89-113.

Rahgozar, S. and Giménez-Llort, L. 2020. Foundations and Applications of Logotherapy to Improve Mental Health of Immigrant Populations in the Third Millennium. *Frontiers in Psychiatry* 11:451.

Rahmati Najar -Kolaie, F., Ebadifard-Azar, F. and Rimaz, S. 2012. Effects of Training Breast-Cancer Screening on Female University Students’ Beliefs. *The Iranian Journal of Obstetrics, Gynecology and Infertility* 15 (23):10-17.

Ramesh, H.K., Mehrak, R., Mohammad-Ebrahim, S., Kamran, B.L., Hassan J. *et al.* 2014. Evaluating Effect of Logotherapy group on Mental Health and Hope to Life of Patients with Colorectal Cancer receiving Chemotherapy. *Bulletin of Environment, Pharmacology and Life Sciences* 3(5):164-169.

Raqibi, M. and Rabani, M. 2012. The Effect of Training Optimism Skills on Emotional Intelligence on the Boys of Correction and Rehabilitation Center of Kerman City. *UGC Care Journal* 14:3:218-211.

Repetti, R. L., Taylor, S. E. and Seeman, T. E. 2002. Risky Families: Family Social Environments and the Mental and Physical Health of Offspring. *Psychological Bulletin* 128(2):330–366.

Reynolds, P., Hurley, S., Torres, M., Jackson, J., Boyd, P., Chen, *et al*. 2000. Use of Coping Strategies and Breast Cancer Survival: Results from the Black/White Cancer Survival Study. *American Journal of Epidemiology* 152:940-949.

Roesch, S.C. and Weiner, B. 2001. A Meta-Analytic Review of Coping with Illness: Do Causal Attributions Matter? *Journal of Psychosomatic Research* 50:205-219.

Rosenberg, H., Jankowski, M.K., Fortuna, L.R., Rosenberg, S.D. and Mueser, K. 2011. A Pilot Study of a Cognitive Restructuring Program for Treating Posttraumatic Disorders in Adolescents. *Psychological Trauma: Theory, Research, Practice and Policy* 3(1):94-99.

Rosenstock, I.M., Strecher, V.J. and Becker, M.H. 1988. Social Learning Theory and the Health Belief Model. *Journal of Health Education and Behaviour* 15(2):175-183.

Rosenstock, I. M. 1974. Historical Origins of the Health Belief Model. *Health Education Monographs* 2:328-335.

Roser, M. and Ritchie, H. 2018. Cancer. Retrieved from: 'https://o.urworldin.data.org/cancer'. (Online Resource).

Sadeqee, S. 2009. Analyzing the Relation of Optimism with Psychological Welfare and Confronting Styles in Students. *Journal of Education and Psychology* 5:32-44.

Saeed, S., Asim, M. and Sohail, M.M. 2021. Fears and Barriers: Problems in Breast Cancer Diagnosis and Treatment in Pakistan. *BMC Women's Health* 21:151

Sandgren, A. K., Mullens, A. B., Erickson, S. C., Romanek, K. M. and McCaul, K. D. 2004. Confidant and Breast Cancer Patient Reports of Quality of Life. Quality of Life Research*: An International Journal of Quality of Life Aspects of Treatment, Care and Rehabilitation* 13(1):155–160.

Sarimiye, F. June 6, 2019. In Debunking Cancer Myths/Misconceptions/Misinformation. Tribune Newspapers Online. Retrieved August 8, 2019 from http://patelacare.org/2019/06/06/debunking-cancer-myths-misconceptions-misinformation/

Sarki, A.M. and Roni, B.L. 2019. This Disease is "not for hospital": Myths and Misconceptions about Cancers in Northern Nigeria. *Journal of Global Health Reports* 3:15-21.

Schlebusch., L. and VanOers, H. 1999. Psychological Stress Adjustment and Cross-cultural Considerations in Breast Cancer Patients. *South African Journal of Psychiatry* 29: 30–35.

Schroevers, M. J., Helgeson, V. S., Sanderman, R. and Ranchor, A. V. 2010. Type of Social Support Matters for Prediction of Post Traumatic Growth among Cancer Survivors. *Journal of Psycho-Oncology* 19:46-53.

Schulenberg, S. E., Hutzell, R. R., Nassif, C. and Rogina, J. M. 2008. Logotherapy for Clinical Practice and Psychotherapy: *Theory, Research, Practice, Training* 45(4): 447–463.

Schultz, T. R. and Schleifer, M. 1983. Towards a Refinement of Attribution Concepts. In J. Jaspars, F.D. Fincham and M. Hewstone (Eds.), Attribution Theory and Research: Conceptual, Developmental, and Social Dimensions (pp. 37–62). NewYork: Academic Press.

Schunk, D.H. 2000. Learning Theories: An Educational Perspective.(2nd ed). New Jersey: Prentice- Hall, Inc.

Schutte, A. E. 2017. Global, Regional and National Age-sex Specific Mortality for 264 Causes of Death, 1980-2016: A Systematic Analysis for the Global Burden of Disease Study, 2016.

Schwarzer, R. and Luszczynska, A. 2005. Multidimensional Health Locus of Control: Comments on the Construct and its Measurement. *Journal of Health Psychology* 10:633-642.

Schwarzer, R. 2001. Social-Cognitive Factors in Changing Health-Related Behaviours. *Current Directions in Psychological Science* 10(2):47–51.

Searle, J.R. 1969. Speech Acts: An Essay in the Philosophy of Language: Cambridge University Press.

Seeman, T. E. 1996. Social Ties and Health: The Benefits of Social Integration. *Annals of Epidemiology* 6(5):442-451.

Servaes, P., Verhagen, S. and Bleijenberg, G. 2002. Determinants of Chronic Fatigue in Disease-free Breast Cancer Patients: A Cross- sectional Study. *Annals of Oncology* 13:589–598.

Seydel, E., Taal, E. and Wiegman, O. 1990. Risk-appraisal, Outcome and Self-efficacy Expectancies: Cognitive Factors in Preventive Behaviour Related to Cancer. *Journal of Psychology and Health* 4:99-109.

Shahabi, S. 2016. The Effect of Logotherapy on Life Orientation of Cancer Patients. *International Journal of Medical Research and Health Sciences* 5(9):240-243.

Shaver. K. G. 1985. The Attribution Theory of Blame: Causality, Responsibility and Blameworthiness. Springer-Verlag.

Sherbourne, C. D. and Stewart, A. L. 1991. The MOS Social Support Survey. *Journal of Social Science and Medicine* 32:705–714.

Siegel, R.L., Miller, K.D. and Jamal, A. 2019. Cancer Statistics, 2019. *Journal of Clinical Oncology* 69 (1): 7–34.

Sitharthan, T. and Kavanagh, D. J. 1990. Role of Self-efficacy in Predicting Outcomes from a Programme for Controlled Drinking. *Drug and Alcohol Dependence* 27: 87-94.

Somani, S. 2009. In Search of Meaning. *PM Network 23*(11):25.

Sontag, S. 1997. Illness as Metaphor and AIDS and its Metaphors. Picador, New York, NY, USA.

Southwick, S., Gilmartin, R., McDonough, P. and Morrissey, P. 2006. Logotherapy as an Adjunctive Treatment for Chronic Combat-related PTSD: A Meaning-based Intervention. *American Journal of Psychotherapy* 60(2):161-174.

Southwick, S.M., Lowthert, B.T. and Graber, A.V. 2016. Relevance and Application of Logotherapy to Enhance Resilience to Stress and Trauma. In book: Logotherapy and Existential Analysis (pp.131-149).

Spatuzzi, R., Vespa, A., Lorenzi, P., Miccinesi, G., Ricciuti, M. *et al*. 2016. Evaluation of Social Support, Quality of Life, and Body Image in Women with Breast Cancer. *Journal of Breast Care* 11(1):28–32.

Speice, J., Harkness, J., Laneri, H., Frankel, R., Roter, D. *et al*. 2000. Involving Family Members in Cancer Care: Focus Group Considerations of Patients and Oncological Providers. *Journal of Psycho-Oncology* 9(2):101–112.

Spiegel, D. 1994. Health Caring. Psychosocial Support for Patients with Cancer. *Journal of Cancer* 74(4):1453-1457.

Spiegel, D., Bloom, J.R., Kraemer, H.C., and Gottheil, E. 1983. Effect of Psychosocial Treatment on Survival of Patients with Metastatic Breast Cancer. *The Lancet* 2:888–891.

Staal, D.P., Vlooswijk, C., Mols, F. *et al*. 2021. Diagnosed with a Common Cancer at an Unusual Age: Causal Attributions of Survivors of Adolescent and Young Adult Colorectal Cancer. *Journal of Support Care in Cancer* 29:409–416.

Sterba, K.R., Burris, J.L., Heiney, S.P., Ruppel, M.B., Ford, M.E. *et al.* 2014. "We both just trusted and leaned on the Lord": A Qualitative Study of Religiousness and Spirituality among African American Breast Cancer Survivors and their Caregivers. *Quality of Life Research* 23(7):1909–1920.

Stewart, B. W. and Kleihues, P. (Eds.). 2003 *World Cancer Report*. Lyon, France: International Agency for Research on Cancer. www.scribd.com/.../World-Cancer-Report

Strazdins, L. and Broom, D. 2007. The Mental Health Costs and Benefits of Giving Social Support. *International Journal of Stress Management* 14:370-385.

Sudhakar, A. 2009. History of Cancer, Ancient and Modern Treatment Methods. *Journal of Cancer Science and Therapy* 1:1-4.

Sulaiman, A. and Uhuegbu, S. 2021. Impact of Cognitive Restructuring and Token Economy Techniques on Truancy Reduction among Secondary School Students in Lagos State, Nigeria. *Islamic Guidance and Counseling Journal* 4(1):21-32.

Sun, F.K., Hung, C.M., Yao, Y., Fu, C.F., Tsai, P.J. *et al* 2019. The Effects of Logotherapy on Distress, Depression, and Demoralization in Breast Cancer and Gyneacological Cancer Patients: A Preliminary Study. *Journal of Cancer and Nursing* 44(1):53-61.

Suwankhong, D. and Liamputtong, P. 2016. Social Support and Women Living with Breast Cancer in the South of Thailand. *Journal of Nursing Scholarship* 48(1):39–47.

Tang, P.L., Chen, W.L. and Cheng, S.F. 2013. Using Logotherapy to Relieve Death Anxiety in a Patient with Recurrent Cancer: A Nursing Experience. *Hu Li Za Zhi* 60(4):105-110.

Tanjasiri, S., Mata'alii, S., Hanneman, M., and Sabado, M. 2011. Needs and Experiences of Samoan Breast Cancer Survivors in Southern California. *Hawaii Medical Journal* 70:35-39.

Taylor, C. B., Bandura, A., Ewart, C. K., Miller, N. H. and DeBusk, R. F. 1985. Exercise Testing to Enhance Wives' Confidence in their Husbands' Cardiac Capability soon after Clinically Uncomplicated Acute Myocardial Infarction. *American Journal of Cardiology* 55:635-638.

Taylor, S.E. 2011. Social Support: A Review. The Oxford Handbook of Health Psychology: 189-214: Edited by Friedman, H.S.

Tesfamariam, A, Gebremichael, A. and Mufunda J. 2013. Breast Cancer Clinico-pathological Presentation, Gravity and Challenges in Eritrea, East Africa: Management Practice in a Resource-poor Setting. *South African Medical Journal* 103(8):526–528.

Tetteh, D.A and Faulkner, S.L. 2016. Sociocultural Factors and Breast Cancer in Sub-Saharan Africa: Implications for Diagnosis and Management. *Journal of Womens Health* 12(1):147–156.

Thoits, P.A. 2005. Differential Labelling of Mental Illness by Social Status: A New Look at an Old Problem. *Journal of Health and Social Behaviour* 46(1):102-119.

Thorne, B. M. and Henley, T. B. 2005. Connections in the History and Systems of Psychology (3rd ed.). Boston: Houghton Mifflin.

Timko, C., and Janoff-Bulman, R. 1985. Attributions, Vulnerability and Psychological Adjustment: The Case of Breast Cancer. *Journal of Health Psychology* 4:521-544.

Toshima, M.T., Kaplan, R.M. and Ries, A.L. 1992. Self-efficacy Expectations in Chronic Obstructive Pulmonary Disease Rehabilitation. In R.Schwazer (Ed.),Self-efficacy: Thought Control of Action (pp.325-354).NewYork: Hemisphere.

Uchino, B.N. 2009. Understanding the Links Between Social Support and Physical Health: A Life-Span Perspective With Emphasis on the Separability of Perceived and Received Support. *Journal of Perspectives on Psychological Science* 4:10.

.... 2004. Social Support and Physical Health: Understanding the Health Consequences of Relationships. *American Journal of Epidemiology* 161: 297-298.

Ulrichová, M. 2012. Logotherapy and Existential Analysis in Counselling Psychology as Prevention and Treatment of Burnout Syndrome. *Procedia-Social and Behavioural Sciences Journal* 69:502

Valdimarsdottir, U., Helgason, A.R., Furst, C.J., Adolfsson, J. and Steineck, G. 2005. Awareness of Husband's Impending Death from Cancer and Long-term Anxiety in Widowhood: A Nationwide Follow-up. *Journal of Palliative Medicine* 18(5):432-443

Van-Kampen, D., Berg, T., Woude, H., Castelein, R., Scholtes, V. *et al.* 2014. The Diagnostic Value of the Combination of Patient Characteristics, History and Clinical Shoulder Tests for the Diagnosis of Rotator Cuff tear. *Journal of Orthopaedic Surgery and Research* 9(1):70.

Van-Ryn, M., Sanders, S., Kahn, K., *et al.* 2011. Objective Burden, Resources, and other Stressors among Informal Cancer Caregivers: A Hidden Quality Issue? *Journal of Psychooncology* 20(1):44–52.

Vaughn, L.M., Jacquez, F. and Baker, R.C. 2009. Cultural Health Attributions, Beliefs and Practices: Effects on Healthcare and Medical Evaluation, *The Open Medical Educational Journal* 2;64-74

Walker, A. J., Pratt, C. C. and Wood, B. 1993. Perceived Frequency of Role Conflict and Relationship Quality for Caregiving Daughters. *Journal of Psychology of Women Quarterly* 17:207-221.

Walker, B., Holling, C.S., Carpenter, S.R. and Kinzig, A. 2004. Resilience, Adaptability and Transformability in Social-Ecological Systems. *Journal of Ecology and Sociology* 9(2):5.

Walsh, S. R., Manuel, J. C. and Avis, N. E. 2005. The Impact of Breast Cancer on Younger Women's Relationships with their Partner and Children. *Journal of Families, Systems and Health* 23: 80-93.

Wang, S.P., Lin, L.C., Lee, C.M., Wu, S.C. 2011. Effectiveness of a Self-care Program in Improving Symptom Distress and Quality of Life in Congestive Heart Failure Patients: A Preliminary Study. *Journal of Nursing Research* 19(4):257–266.

Weber, B.A., Roberts, B.L., Resnick, M., Deimling, G., Zauszniewski, J., *et al.* 2004. The Effect of Dyadic Intervention on Self-efficacy, Social support, and Depression for Men with Prostate Cancer. *Journal of Psycho-Oncology* 13:47–60.

Weinberg, R. S., Gould, D., Yukelson, D. and Jackson, A. 1981. The Effect of Pre-existing and Manipulated Self-efficacy on Competitive Muscular Endurance Task. *Journal of Sport Psychology* 4:345-354.

Weiner, B. 1995. Judgments of Responsibility: A Foundation for a Theory of Social Conduct. Guilford Press.

Wells, A.A., Gulbas, L., Sanders-Thompson, V., Shon, E.J., Kreuter, M.W. 2014. African-American Breast Cancer Survivors Participating in a Breast Cancer

Support Group: Translating Research into Practice. *Journal of Cancer Education* 29(4):619–25.

Wenzel, A. 2017. Basic Strategies of Cognitive Behavioural Therapy: Psychiatric Clinics of North America 40:(4):597-609.

White, C.A. 2011. Cognitive Behaviour Therapy for Chronic Medical Problems: A Guide to Assessment and Treatment in Practice: John Wiley and Sons Ltd.

Wiedenfeld, S.A., O'Leary, A., Bandura, A., Brown, S., Levine, S., *et al*. 1990. Impact of Perceived Self-efficacy in Coping with Stressors on Components of the Immune System. *Journal of Personality and Social Psychology* 59:1982-2094.

Wiese, D.M. and Klint, K.A. 2009. Head over Heels with Success: The Relationship between Self-efficacy and Performance in Competitive Youth Gymnastics. *Journal of Sport and Exercise Psychology* 11:444-451.

Wills, T.A. 1990. Multiple Networks and Substance Use. Special Issue: Social Support in Social and Clinical Psychology. *Journal of Social and Clinical Psychology* 9:78-90.

Wills, T. A. and Filer, M. F. 2001. Social Networks and Social support. In A. Baum, T. A. Revenson, and J. E. Singer (Eds.), Handbook of Health Psychology (pp. 209–234). Mahwah, NJ: Erlbaum.

Wimberly, S. R., Carver, C. S., Laurenceau, J. P., Harris, S. D. and Antoni, M. H. 2005. Perceived Partner Reactions to Diagnosis and Treatment of Breast Cancer: Impact on Psychosocial and Psychosexual Adjustment. *Journal of Counselling and Clinical Psychology* 73(2):300-311.

Wolgast, M., Lundh, L. and Viborg, G. 2013. Cognitive Restructuring and Acceptance: An Empirically Grounded Conceptual Analysis. *Journal of Cognitive Therapy and Research* 37:2.

Wonders, K.Y., Spellman, C.E., Tse, L.M., Wonders, A.W. and Stout, B. 2017. Current Trends in Cancer Support Within the Religious Community. *Journal of Nursing and Palliative Care* 2: (4):1-4.

Woods, N.F. and Earp, J.L. 1978. Women with Cured Breast Cancer: A Study of Mastectomy Patients in Nort.h Carolina. *Journal of Nursing Research* 27:279-285.

Woolfson, L. 2003. Disabled Children, Parents and Society–A Need for Cognitive Reframing. *Proceedings of the British Psychological Society* (1):5.

World Health Organisation, 2015. Cancer Factsheet available at www.who.int/medi.acentre/factsheets/fs297/en/

.... 2018. "Cancer Factsheet No 297". Retrieved 21st March, 2018.

.... 2014. World Cancer Report pp. Chapter 1.1. *ISBN 9283204298*.

.... 2018. Cancer. Downloaded on 31 October 2018.

Wright, S.V. 1997. An Investigation into the Causes of Absconding among Black African Breast Cancer Patients. *South African Medical Journal* 87:1540–1543.

Yalom, I. D. 1980. Existential Psychotherapy. New York: Basic Books.

Yilmaz, D., Bebiş, H. and Ortabag, T. 2013. Determining the Awareness of and Compliance with Breast Cancer Screening among Turkish Residential Women. *Asian Pacific Journal of Cancer Prevention* 14: 3281-3288.

Yucel, S.C., Orgun, F., Tokem, Y., Avdal, E.U., Demir, M. 2014. Determining the Factors that affect Breast Cancer and Self -breast Examination Beliefs of Turkish Nurses in Academia. *Asian Pacific Journal of Cancer Prevention* 15(3):1275-80.

Yurica, C.L and Di-Tomasso, R.A. 2005. Cognitive Distortions. In Felgoise, S., Nezu, A.M., Nezu, C.M. and Reinecke, M.A. (Eds.), *Encyclopedia of Cognitive Behaviour Therapy* (pp. 117-122). Springer, Boston, MA.

Yusuf, I., Atanda, A.T, Umar, A.B., Imam, M.I., Mohammed, A.Z., *et al.* 2017. Cancer in Kano, Northwestern Nigeria: A 10-year update of the Kano Cancer Registry. *Annals of Tropical Pathology* 8:87-93

Yzer, M.C.and Vanden P.B. 2006. Understanding Smoking Cessation: The Role of Smokers' Quit History. *Psychology of Addictive Behaviours* 20:356–361.

Zaiser, R. 2005. Working on the Noetic Dimension of Man: Philosophical Practice, Logotherapy and Existential Analysis. Philosophical Practice*: Journal of American Phillosophical Practice* 1(2):83-88.

Zemore, R. and Shepel, L. F. 1989. Effects of Breast Cancer and Mastectomy on Emotional Support and Adjustment. *Journal of Social Science and Medicine* 28:19-27.

Zhang, L., Schwarz, J., Kleinstäuber, M., Fritzsche, K., Hannig, W. *et al.* 2018. Confirmatory Factor Analysis of the Causal Illness Attribution Scale in Chinese Patients with Multiple Somatic Symptoms. *Journal of Psychology, Health and Medicine* 23(1):1318-13.

APPENDIX I

DEPARTMENT OF COUNSELLING AND HUMAN DEVELOPMENT STUDIES

FACULTY OF EDUCATION

UNIVERSITY OF IBADAN, IBADAN, NIGERIA

This questionnaire was designed to collect information from you concerning your health. It is purely for academic purpose and all information supplied will be treated with utmost confidentiality.

Please indicate the extent to which you agree or disagree with the following statements concerning your health status.

Thank you.

Section A: Personal Data

Please respond as appropriate

Sex: Male ( ) Female ( )

Age: ………….

Type of cancer? ....

Stage of cancer: (One) (Two) (Three) (Four)

Educational Qualification: ……………………

Marital Status: Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed ( )

Section B : The researcher is interested in your own personal views of how you see your current illness.

Please indicate how much you agree or disagree with the following statements about your illness by ticking the appropriate box.

Blame Attribution Questionnaire (Screening instrument)

Key:

SA-Strongly Agree

A-Agree

D-Disagree

SD- Strongly Disagree

S/N	Items	SA	A	D	SD
1	I find somebody to blame for my health condition				
2	I see myself as not being responsible for my current health condition				
3	I excuse myself but blame others for my health condition				
4	I have to blame others to preserve my dignity				
5	To escape shame, I hide the rationale behind my health condition				
6	I must pass blame to others to split-off my feeling of condemnation				
7	I have to blame so that I will not be the only one in bad mood				
8	I have to blame to avoid loss of control of my health condition				
9	I have to blame others to ease myself from frustration and depression				
10	I have to blame to improve my personal integrity				
11	I blame to ease myself of despair				
12	I blame to ease myself of mental stress				
13	In any bad situation, I am prone to ask myself "Why me?"				
14	I will rather go for self-defense than to admit my errors				
15	I blame mostly to overcome my health problem				
16	Most of the time, I blame to ease myself from being anxious				
17	At times, I blame others to ease myself from all forms of emotional trauma				
18	I blame others to hide my feeling of guilt in bad situations that I ought to prevent				
19	I blame others to hide my feeling of responsibility of a mishap under my control				
20	I attribute some of my problems to the devil				

Modified Attributions for Serious Illness Scale

Key:

SA-Strongly Agree

A-Agree

U-Undecided

D-Disagree

SD-Strongly Disagree

S/N	Items	SA	A	U	D	SD
1	This disease is not as a result of my lifestyle					
2	I believe that this disease is a work of my adversary					
3	I contracted the disease through heredity					
4	I did nothing to contract it, it is just my luck to contract it					
5	Being infected with this disease is not within my power or control					
6	I contracted it because of lack of proper awareness of the nature of the disease and how to prevent it					
7	I contracted it because of my carelessness to health issues					
8	I contracted it from exposure to sun rays					
9	I contracted it because the government did not provide free medical care					
10	I strongly believe that I am predestined to contract it					
11	I contracted it not because of what I take in, but because of my age					
12	I contracted it because my body immunity is low					
13	I did nothing to contract it, it is just a trial of my faith					
14	I contracted it due to consumption of chemically processed foods					
15	I am not careless about my health, only that I got infected through environmental pollution					
16	My infection of cancer is a result of generational curse/ spell					

17	Poor economy hindered me from taking healthy diet, this exposed me to the disease					
18	The origin of my infection is mystical/supernatural					
19	Low socio-economic status led to easy contraction of this disease					
20	My view of cancer is quite different from the view of medical personnel					
21	I am not careless about my health, cancer was an attack from evil spirit.					
22	I contracted cancer because of the weakness of government policies to ban chemically processed foods.					
23	My infection of cancer is not from my poor dietary habits.					
24	I contracted cancer because of the inefficiency of government agencies to ensure that preservatives are not excessively added to foods.					
25	I contracted cancer because of government's inefficiency to legislate against and apprehend those whose activities pollute the air.					

Health Self-Efficacy Scale

Key:

SA- Strongly Agree

A-Agree

U- Undecided

D- Disagree

SD- Strongly Disagree

S/N	Items	SA	A	U	D	SD
1.	I am confident that I can have a positive impact on my health.					
2.	I have set some clear goals to improve my health.					
3.	I have been able to achieve the goal of improving my health.					

4.	I am actively working to improve my health.					
5.	I feel that I can control how I understand my health.					

Social Support Scale

People sometimes look to others for companionship, assistance or other types of support. How often is each of the following kinds of support available to you if you need it? Tick one number on each line.

1= None of the time

2= A little of the time

3= Some of the time

4= Most of the time

5= All of the time .

S/N	Items	1	2	3	4	5
	Emotional/informational support					
1.	People you can count on when you need to talk					
2.	Someone gives you information to help you understand the situation					
3	Someone gives you a good suggestion about the crisis					
4	People you can talk to about yourself or your problem					
5	Someone whom you really want his advice					
6	People who can share your most intimate concerns and fears with you					
7	Someone to ask for advice on how to deal with personal issues					
8	The person who knows and understands your problems					
	Tangible support					
1	If you are trapped in bed, someone can help you					

2	Someone will take you to the doctor if needed.					
3	If you can't do it yourself, there is someone to prepare your meals.					
4	If you are sick, someone can help with housework.					
	Affectionate support					
1	Someone shows you love and care					
2	Someone loves you and makes you feel accepted					
3	Someone hugs you					
	Positive social interaction					
1	Have a good time with someone					
2	Someone relaxing together					
3	Someone gathered together to relax					
	Additional item					
1	Someone to do things with to help you get your mind off things.					

APPENDIX II
RESPONDENTS' INFORMED CONSENT FORM

Title of the Research

Effects of Logotherapy and Cognitive Reframing on Blame Attribution among Newly Diagnosed Cancer Patients in Southwestern Nigeria.

Name and Affiliation of Researcher: This study is being conducted by IBITOYE Shakirat Bolanle of the Department of Counselling and Human Development Studies, Faculty of Education, University of Ibadan, Ibadan, Nigeria.

Sponsor of Research: This research is self-sponsored.

Introduction: The diagnosis of cancer is often associated with several issues that affect an individual's emotional coping, adjustment and proper functioning.

Purpose of the research: The main purpose of this study is to investigate the effects of LT and CR on blame attribution among newly diagnosed cancer patients in Southwestern Nigeria.

Procedure of Research: A total of 81 participants will be recruited into the study. You will be exposed to eight weeks of intervention in LT or CR techniques (chosen through the ballot) after the pre-test instrument has been administered. A post-test instrument will be administered after the intervention for data analysis.

Potential Benefits: The goal of this research is to contribute to reduction in the mortality rate among cancer patients by using interventions aimed at reducing blame attribution rates and increasing adherence to cancer treatment. It is also aimed at improving your attitude towards the diagnosis of cancer and treatment.

Potential Risks: The study is not expected to pose any risk to participants

Expected Duration of Research: You are expected to be involved in this research for eight weeks. You should not spend more than one hour during each session.

Costs to the participants for joining the research: Your participation in this research will not cost you anything except the time devoted for participation.

Confidentiality: No names will be used in this study, codes and serial numbers are to be used during data collection to ensure confidentiality of information. All information collected in this study, publications or reports from this study will be strictly confidential and cannot be linked to you in anyway.

Voluntariness: Your participation in this research is entirely voluntary.

Alternatives to participation: You are free to withdraw your participation in the study if you wish to do so and this will not affect your treatment in the hospital in anyway.

What happens to Research participants and Communities when the Research is over: The researcher will inform you of the outcome of the research through a follow-up session.

Conflict of Interest: There is no conflict of interest whatsoever.

Due inducement: You will be compensated for cost of transport to and from the research site but you will not be paid any fee for participating in the research.

Statement of Person Obtaining Informed Consent:

I have fully explained this research to the respondent and given sufficient information, including the risks and benefits, to make an informed decision.

DATE:………………………. SIGNATURE………………………………

Statement of Person Giving Consent:

I have read the description of the research. I understand that my participation is voluntary. I know enough about the purpose, methods, risks and benefits of the research study to judge that I want to take part in it. I understand that I may freely stop being part of this study at any time. I have received a copy of this consent form to keep for myself.

DATE:…………………………… SIGNATURE:…………………………

SERIAL NO:…………………………………………

This research has been approved by the ethics committee of the following centres:

1. **UI/UCH Ethics Committee**
Biode Building, Room 210, 2nd floor, Institute for Advanced Medical Research and Training, College of Medicine, University of Ibadan.
E-mail: uiuchirc@yahoo.com and uiuchecgmail.com

2. **LUTH Health Research Ethics Committee's Contact**
Room 107, Administrative block
Lagos University Teaching Hospital,
Idi- Araba, Lagos.

3. **FMC Health Research Ethics Committee**
Bisi Onabanjo way,
Idi-Aba,
Abeokuta.

If you have any question about your participation in this research, you may contact the researcher, IBITOYE Shakirat Bolanle from the Department of Counselling and Human Development Studies, Faculty of Education, University of Ibadan, Ibadan, Nigeria.

Phone: 08029441638

email: ibitoyebolanle@yahoo.com

APPENDIX III
YORUBA VERSION OF INSTRUMENTS, INFORMED CONSENT FORMS AND TREATMENT MANUALS

*B##R$ *TAKOR+S{ L(R& D&DQRA CSILEBE ($R)JA *GB#L#W+N)

Zt-nz

SA : Mo gbz b12 gan-an ni
A : Mo gbz
D : N k0 gbz
SD : N ko gbz bcc rara

s/ n	Item	SA	A	SD	D
1	Mo ê wq cni ti mo le ru 2bi ip0 8lera mi ru				
2	Mo ri ara z mi g1g1 bi wipe 4mi k- l9 fa aye ipo zilerz a mi l--l--				
3	Mo ya ara z mi s-t=, x6gb-n ru 2bi zilerz a mi le zw[n t9 k6 l9r7				
4	Mo ni lqti dqzb0 bo iy8 ara z mi nipa d7dq zw[n to yi mi ka lcbi				
5	Mo gb3 zr0y3 mi s1gb2 1 kan k7 n l4 ba z b- l-w- 8t8j5				
6	Mo gb[d= da zw[n toku ti n j[wa ninu ip0 z8lera y87 l1bi ki [kzn mi le f5y1 lori ero 8dql3bi				
7	Nitor7 k9 m- mq bqz jc 4mi nikan n7 9 wa ninu 8bzn5j1 mo ni lqti mqa dqni l1bi i				
8	Ki n ma baa s[eto 8szk9 ara a mi nu, mo ni lqti mqa dani l1b7 7				
9	K7 n le 4 gba ara z mi l[w[8p0r5ur6 ati 8r2w2si [kan, mo ni lqti mqa dq zw[n t9k6 l1bi				
10	D7dq ara z mi lcbi yoo ru 8joloot[mi soke				
11	Mo ê dqni lcbi lqti gba ara z mi l-w- z8n7r4t7				
12	Mo ê dqni lcbi lqti gb[nran6 l-w- [8r0n5 zbaad8				
13	N7n5 zy4kay4 b5bur5, mo wz n7 ip0 zti bi ara mi l34r3 pe “9 xe j3mi n7n5 ilak[ja naa?				
14	N 9 gb4 ti ara z mi j6 lqti gba zx8xe emi t7 9 le m5 8tij5 bami				
15	Mo ê dqni l1bi l-p= 8gbz lqti bor7 8x0ro z8lera z mi				
16	N7 =p= 8gbz, mo ê dqni l1bi lqti mu zd7nk6 ba 8p0r5ur6				

	mi				
17	Mo mqa ê da zw[n ti o yi mi ka lcbi lqti m5 zd7nk6 ba zw[n or7sir7si 8p0r5ur6 apani n7vzm78				
18	Mo mqa ê dq zw[n t9k6 l1bi lqti f'2bi 8m=lqra z mi pam-n7 z8t- gbogbo t7 9 ye k7 n ycra f5n				
19	D7dq t7 mo n da zw[n toku lci ni lati fi zf[w-fz 8m=lqra ewu t7 9 wz ni isakoso mi pam[				
20	Mo fi =p= 8s=r[= mi sun zm5wq 4x6				

IGBELEW{N ZFIS^N *DQL# BI

Zt-nz

SA	:	Mo gbz b12 gan-an ni
A	:	Mo gbz
U	:	Z8pinnu
D	:	N k0 gbz
SD	:	N ko gbz bcc rara

s/ n	Item	SA	A	U	D	SD
1	Ki i xe =nza ti mo gba gbe ay3 4 mi l9 fa z7szn y87					
2	Mo gbzgb- p3 [ta l9 fz q (Zj1 ati ox9)					
3	Mo z8szn y87 n7pa zjcb7					
4	N 0 r8n l-nz zti k9 o o, zm5wq ni					
5	P3 mo n7 z8saç y87 0 s7 agbqra tabi 8szk9so mi lqti k=-					
6	Z8n7 7p4sqkiy4si t9t9 nipa ir5f1 z8szn t77 xe zti =na lqti d4nz rc ni mo xe l6gbzd8 aisan y87					
7	Nipa zijqfara si 4t0 8lera gbogbo l9 m5 mi k9 aisan y87					
8	Mo k9o nipa w7wz n7n6 ow- 0r6n					
9	*joba ti ko pese 8w0szn =f1 l9j1 n l6gbzd8 k9 o.					
10	Mo ni 8gbzgb- to jinl2 w7pe ati k[- m- 8p7n 8n mi pe n ko					
11	Mo ni aisan y87 n7tori [j[orii mi, x6gb[n k87 xe n7tor7 ohun t7 mo ê je					
12	$r0jz t7 9 le 4 k[z8szn y87 n7ye n7nu zg[ara z mi lo jc n n7					
13	Idanwo 8gbzgb- ni, k87 xe zf[w-fz a mi					
14	Mo ni z8szn y87 nipa j7jc zw[n o5njc t7 a fi kcmi kzli p44l0 r2					
15	N 0 xe alq8jqfara nipa 4t0 8lera a mi, 9 kzn j1 p3 mo k9 o nipa 8d-ti agb4gb4					
16	Zk9rzn z8szn jejere t7 mo n7 jc zy[r7s7 eg6n 8d7l3					
17	4t0 8s5nq mi t7 9 bur5jq8 lo xad4nz mi lqti jc o5njc ti o dara, eyi si f5n z8szn naa l9re =f1 zti mu mi					

18	Or7sun z8szn mi y87 0 xe e wqd87					
19	B9yq cbi mi ni tzb7 cbi mi k-, o p[n dandan fun mi lati da 2bi ru zw[n t7 9 y7 mi kq					
20	8w00 mi nipa z8szn jcjcrc yzt= d72 nipa b3 zw[n el3t0 8lera xe w0 9					
21	N k0 gb=j2g1 n8pa 4t0 8lera a mi, jcjcrc j1 zrqns3 lqti [w- emi 4s6					
22	Zx8xe 4t0 zm5l0 8j[ba l9r7 zti dckun zw[n o5njc zfik3m7kzl7 p0 p= lo mu mi ni z8szn y87					
23	Z8szn jcjcrc ti mo nipa 8xow- jcun mi t7 k0 dqra					
24	Mo ni jcjcrc n7tori z8kqpq zw[n zj[8j[ba lqti lqp=j6 n7n5 o5njc					
25	Mo ni jcjcrc n7tori 8j[ba o xe takuntkun to lqti gbe 0fin kql2 zti lqti pal2m- zw[n t7 8xe e w[n n ba afcfc jc					

***PELE IPQ $T) *LERA ARA CNI**

Zt-**nz**

SA : Mo fara m- [n gan

A : Mo fara m- [n gan

U : Z8pinnu

D : N k0 gbz b21

SD : N ko gbz b12 rara

s/ n	Item	SA	A	U	SD	D
1	Mo ni 8gboyz pe mo le ni ipa rere lori eto ilera mi					
2	Mo ti piya zw[n afojusun to dqj5 t7 mo le lo lqti sqtunxe 8lera z mi					
3	Mo ti kcsc jari lori zw[n =nz afojusun ti mo le lo lati xzt5nxe 8lera z mi					
4	Mo n xix1 takuntakun lqti xzt5nxe nipa 8lera z mi					
5	Mo lero pe 8kqpq z mi si bawo ati kini ohun t7 mo ê k[nipa ilera a mi					

*PELE ATILCYIN ZW^J{

Dic ninu igba ni zw[n 44yan maa n wo zw[n arq a w[n fun zj[xep=, iranwo, tabi zw[n atilcyin miran

Bawo ni =k==kan ninu zw[n ir5f1 atilcyin w0ny7 xe n wa ni zr-w-t9 f5n [s7 nigba ti o ba n7l0 rc? Y7 zm8 0do si n-åbz kan n7 k==kan.

1: Ko si eyi ti o jcy[n7n5 zw[n zk9k0

2: K3k3r3 ni akoko nqz

3: D72 n7n5 zk9k0

4: L[p[igba

5: Gbogbo zk9k0 nqz

Zt8lcy8n *m=lqra

s/ n	Item	1	2	3	4	5
1	Cnikan ti o lee f[kan tan lqti t1t7 s7 [n7gbz t7 o ba ni lqti s=r=					
2	Cnikan ti o ni lqti s4rznw- =nz zbqy[f5n [lqti ni 0ye 8lzk[jq a rc					
3	Cn8kan t9 n7 lqti gbz [n7 im[ran lori 8doj5k[= rc					
4	Cnikan ti o lee f[kzn tqn tzb7 bqs=r= nipa ara z rc tzb7 8x0ro rc					
5	Cnikan ti o j1pe o kanl2 feran 8m=rzn rc					
6	Cnikan lqti ba j7r0r0 nipa =p= 8p0r5ur6 ik[k[ati 2n8 rc					
7	Cnikan ti o le k[j5 si fun zbq n7pa b7 o ti xe le yanj5 zw[n 8x0ro ara cni 8 rc					
8	Cnikan ti 0ye 8x0ro 0 rc ye					

Zt7lcy8n to gb[ngb-/oj5l9w9 zt8lcy8n

s/ n	Item	1	2	3	4	5
1	Cnikan to le l4 jc ol6gb=w- fun [b7 o bq wa ni 8d6bul2 z8szn					
2	Cnikan to le 4 mu [l[d-k7tz bi o ba n7l0 o r2					
3	Cnikan to le 4 xe 8rznw- inqd7dq fun [bi o ko ba le xe 3 f5n ra z rc					
4	Cnikan to le4 jc oluranl[w[f5n [lqti xe 'x1 il3 bi o bat					

	c [d72					

Zt7lcy8n T8f1t8f1

s/ n	Item	1	2	3	4	5
1	Cnikan to n fi f1 =p=l[p= hzn s7 [					
2	Cnikan to f1rzn to si jc o ni 8m=lqra pe 0un f3 [- r7					
3	Cnikan t9 mqa ê d8m- [					

Ipa Rere Zjosep=/Ipa Rere *bqracnix3p=

S/ n	Item	1	2	3	4	5
1	Cnikan t7 o le4 lo akoko rcp2l5					
2	Cnikan ti o le4 wa pclu fun 8gbaf1					
3	Cnikan ti c le f[gbqf1					

Zfik5n ohunkan

S/ n	Item	1	2	3	4	5
1	Lati gb'[kan rc kuro lara zw[n ero kan, o n7l0 alqbzs3nkznp=					

IWE MO GBO MO GBA

Ilana Iwadi IRB Awọn nọmba: ####

Ilana yii yoo pari ni: OJO / OSU / ODUN

Akọle Iwadi

Awọn ipa ti Logotherapy ati Imọ Ti o ni imọran lori ibawi ẹbi laarin Awọn Alaisan Titun Aisan jejere ni Southwest, Nigeria.

Oluwadi: Iwadi yii ni a nṣe nipasẹ Ibitoye Shakirat Bolanle ti Itọnisọna ati Igbani ni imọran ti Yunifasiti ti Ibadan, Nigeria.

Onigbowo: Iwadi yii ni ifọwọkan ti ara ẹni.

Idi iwadi yii ni lati ṣawari awọn ipa ti logotherapy ati awọn iṣaro imọ lori ibawi ẹbi laarin awọn alaisan aisan jejere titun ni aarin Southwest, Nigeria.

Ilana Iwadi: Apapọ gbogbo awọn alabaṣepọ ogbon ni ao gba sinu iwadi naa. Won yoo farahan si awọn ọsẹ mẹjọ ti ijabọ ni logotherapy tabi awọn imọ-imọ-imọ imọ-ọrọ (ti a yàn nipasẹ awọn idibo) lẹhin ti a ti fi ohun-elo idanimọ ṣaaju ṣe. Aṣayan igbeyewo ifiweranṣẹ yoo wa ni abojuto lẹhin igbiyanju fun iṣeduro data.

Akoko Iwadi: O yẹ ki o wa ninu iwadi yii fun ọsẹ mẹsan. O yẹ ki o ma lo ju wakati kan nigba igbasilẹ kọọkan.

Awọn ewu: A ko ṣe yẹyẹ iwadi naa lati jẹ ki eyikeyi awọn alabaṣepọ ni ewu kankan.

Awọn owo si awọn olukopa fun didopọmọ iwadi: Iṣepa rẹ ninu iwadi yii kii yoo jẹ ohunkohun fun ọ bikoṣe akoko ti a fi fun ikopa.

Awọn anfani: Idi iwadi yii ni lati ṣe alabapin si idinku ninu iye oṣuwọn laarin awọn alaisan jejere nipasẹ lilo awọn ilowosi ti a ni idojukọ lati dinku awọn iyasọtọ ibajẹ ẹbi ati ki o mu ikunmọ si itọju jejere.

Imulẹ: Ko si awọn orukọ ti yoo lo ninu iwadi yii, awọn koodu ati awọn nọmba ni tẹlentẹle ni a gbọdọ lo lakoko gbigba data lati rii daju pe imulẹ ifitonileti alaye o wa. Gbogbo alaye ti a gba ni iwadi yii, awọn iwe tabi awọn iroyin lati inu iwadi yii ko le ṣe asopọ mọ ọ ni gbogbo ọna.

Iyọnda: Ifarahan rẹ ninu iwadi yi jẹ ẹbun ọfẹ.

Awọn iyokuro lati kopa: O ni ominira lati yọ ifarahan rẹ ninu iwadi naa ti o ba fẹ lati yọ kuro ati wipe eyi kii yoo ni ipa lori itọju rẹ ni ile-iwosan ni gbogbo ọna.

Imudaniloju: Iwọ yoo gba owo fun ọkọ lati lo ibi iwadi ṣugbọn iwọ kii yoo gba owo

eyikeyi fun kopa ninu iwadi naa.

Gbólóhùn ti eniyan ti o n gba ifitonileti nipa imọran:

Mo ti salaye gbogbo iwadi yii fun -- ----------------- ti o si ti fun alaye ti o to, pẹlu awọn ewu ati awọn anfani, lati ṣe ipinnu .

DEETI: .... IFOWOSI: ....

ORUKO: ....

Gbólóhùn ti eniyan fifunni:

Oye mi wipe ikopa mi jẹ atinuwa. Mo mọ nipa idi, awọn ọna, awọn ewu ati awọn anfani ti iwadi iwadi lati ṣe idajọ pe Mo fẹ lati ṣe alabapin ninu rẹ. Oye mi wipe mo le daa duro ni apakan ninu iwadi yii nigbakugba. Mo ti gba ẹda ti fọọmu ifowosi ati folda alaye lati pa fun ara mi.

DEETI: .... IFOWOSI: ....

NUMBA: ....

Iwadi yii ti di fi fọwọsi nipasẹ igbimọ Ethics ti Yunifasiti ti ilu Ibadan ati alaga igbimọ yii ni a le kansi ni ile Biode, yara 210, 2nd floor, Institute for Advanced Medical Research and Training, College of Medicine, University of Ibadan, E - mail.uiuchirc@yahoo.com ati uiuchecgmail.com.

Ni afikun, ti o ba ni ibeere eyikeyi nipa ilowosi rẹ ninu iwadi yii, o le kan si oluṣewadii akọkọ:

Orukọ: IBITOYE SHAKIRAT BOLANLE.

Adireesi : Yunifasiti ti ilu Ibadan

Foonu: 08029441638 E-mail: ibitoyebolanle@yahoo.com

***T_S_NZ FUN *T(J%**

@GB! K&NN& F%N &SZDQNW) X&XE *WAD*& AY# ARACNI FUN IDALEBI LQZR&N ZW{N T& O N& Z*SZN AKZN

Ilepa *t=j5: Ohun t9 j1 agbqtcru il3pa 8dqs7 ni lqti szm5l0 zw[n =nz 8s4wqd8 7 zra cni nipa ta lz bq dqlcbi lori z8szn jcjcrc t7 a x2x2 xe iwadi laarin zw[n ti o nii.

Sqz K7nn7

Zk0r7 =r= *fqz gbogbogb0, *dqnil1k=-, 8kqd87 ati 8pele to xqqj5 *szk9so

$r0çgbz: Ki 8gbz 8x4wad87 y87 o to par7, ol6wqd87 nqa y9 le4:

i. Szgb3kal2 8lznz 8t-j5 t7 9 ba akopa lqra mu;

ii. Fun zw[n olukopa ni 8dqnil1k=- nipa zgb3kal2 at7 8lznzzêt= l0r7 ck[ohun [na it[ju;

iii. Se 8xzk9so ohun z q se s7 ohun elo lqti l4 szk9jo 4s8 abqjq de

Ix1]x7xe:

***gb3s4 k7nn7:** Ol6wad87 nqz ki zw[n olukopa kqzb0 tzy3s7]tay3s7 ibi eto naa.) s'afihan ara rc nipa six[rc ati ol6wad87 nqz f-=m6 [w- w[n lqti le e s4 t-j5 4roçgbz at8 zxe 8k9pa a w[n.

***gb3s4 keji:** Ol6wad87 d87 8f8d7m5l2 asoy3p= lqzqr7n 0un zti zw[n ol6k9pa n7pa f7fzzy4 s7l4 fun ol6wqd87 at7 ak0pa lqti szfihzn ara w[n.

***gb3s4 kcta:** Ol6wad87 p4s4 zw[n 8foj5s7 ohun t7 4t0 nqz da le lori. O salaye nipa ohun 4l0 8l3pa f5n 8t-j5, pztzk8 zti znfzzêi gbogbo t7 ol6k9pa le4 n7 bi 4t0 naa bq par7. Ol6wad87 fi dq zw[n ol6k9pa l9j5 pe zs7ri 7 w[n wa labc abo t7 9 xe 3 sinmi le lqk0k0 8wqd87 zti l1y8n 8dqs8 i r2.

***gb3s2 kcrin**: W-n j1 k7 zw[n ol6k9pa m[w7p3 ipele mej[ni idasi naa j1 f5n wqkzt7 kan nigba ti o ba n waye. Igun mejeeji se fi ohus[kan l9r7 8gbz q ti zk9k0 fun zw[n abala t9 kii.

***gb3s4 karun]un:** Ol6wad87 zti w[n ol6k9pa ni zj[s[y3p= nipa zlzkal2 to xagbqtcr6 8h6wzs7 8wqd87 nqz. Oj5se]z]q]ret7 lqti =d= qw[n ol6k9pa ni ol6wad87 xe lqlzy3 y3k3y3k3.

***gb3s4 kefz**: Zw[n ohun zql0 sqqj5 (Zw[n ohun 4l0 8gb3l3w=n f5n 8dql1bi, 8pele zt8l1yin zw6j[ati 8pele ipq 4t0 8lera ara cni) la xe lqlzy3 s7 zw[n ol6k9pa pelu it[ni t7 9 p3ye lqt[w- ol6wad87 at8 am7g'bql3gb21 c w[n gbogbo.

M7m5 Xqz $k- Wq S0pin

i. Ol6wqd87 nqz xe 8kqd87 2k- naa ni x9k7

ii. Zw[n ol6k9pa nqz gba ix3]zxelil3wq lqti ka abala k7nn7 8w3 naa: *wad87 4n8yzn fun 8tum= lqt[w-[Victor Frankl

iii. Ol6wqd87 naa xe zpap[4k- t9 ê b= ni x9k7

iv. W-n xe szdqnkqtz s7 zw[n ol6k9pa f5n 8wz 8f[w-xow9p0 zti zk9k0 o w[n

v. Ol6wqd87 dupc l-w- [w[n b12 ni 0 s8 =r= 8w5r7 s7 w[n p2l5 l-kzn lqti k0pa n7 4t0 2k- to ê b=. bqkan nqz l9 rqn w[n l3t7 [j-, zk9k0 zti ibi t'ck= - t9 ê b= 9 ti wqy3.

vi. Ol6wqd87 m5 2k- wq s7 8dqnid5r9

Sqz @k- Keji

Zk0r7 @k-: Itan Z8szn Ol6k9pa, *dqnim- zti *tum=

$r0çgbz: B7 2k- y87 xe n pari l[, olukopa yc k9 le 4

i. Szp4j5we ir5f1 8tzn sejcre c w[n

ii. Xzlzy3 ip0 w[n k9 t9 di p3 zti l1y8n zy2w0 z8szn jcjcrc

iii. Ni 0ye to gb[ngb-n nipa ohun ti oj5l9w9 8dqn im= w[n i xe zti ipa ti jcjcrc n7 lee l9r7

iv. N7 8m-r7r8 pataki y7yan 8h6wzs7 8 w[n zti 8hz t7 w-n k[si 8gbe ay3 0diw[n zti 8lak[jq.

Ix1]x7xe:

***gb3s4 k7nn7:** Ol6wad87 ki zw[n ol6k9pa kqzb0 s7 saa kej8 4t0, ati gb7gb9r7y8n f5n w[n bi w-n xe f'zk9k0 o w[n j8n.

***gb3s4 keji:** Ol6s4wad87 szgb3y2w0 ix3 zsetil3wq p2l5 zw[n ol6k9pa. O xe zlzy3 l9r7 k9k0 pztzk8 inu8w3e: "Iwad87 44yzn fun 8tum= s7 7bqmu p4l5 4r9ngbz 8wqd87 zti p2l5 k7 w-n xzxzr0 l9r7 zw[n zk0r7 t7 zw[n alqra xzwqr7 n7gbz t7 w[n ka 8w3 nqz

***gb3s4 kcta:** Ol6wad87 szgb3kal2 k9k9 2k- f5n 8j7r0r0 [j- naa zti b7 w-n xe gbzw-n n7yznj5 lqti szp4j5we 8tan z8l4ra zw[n (*r7r7 w[n kqn t9 xzy4w0 zti b7 w-n xe xzy4w0 8wad87 z8szn jcjcrc gan]an. Lqti 7bcrc zy2w0 8wzd77 t7t7 kan 8m=lqra a r2 lara, 8bcrc zy2wo 8wad77 t7t7 kan 8m=lqra a r2 lara, l1m87 zti lqw6j[, b7 k--wq ti ê s[8tzn rc, ol6wqd87 n szk7y4s7 zw[n k9k9 pztzk8]pztzk8 fun 8j7r0r0 t9 ê b=.

***gb3s2 kcrin**: Zw-n ol6k9pa jqfqfq lqti x4 rqnt7 zw[n 8r7r7 zw[n zk9r0 t7 w-n ti ni 8m5xc lqy3 ko to di zk9k0 8wqd87. W-n n7 k7 w[n n7 zt5nr0 n7pz 8r7s7 i w[n, zw[n ohun ti w-n yan lqzy0 lzti ma axe, zw[n cni t7 w-n ti n7 8bqpzd3 zlqqfiz p2l5, zti b7 8s2wqd87 zr6n jcjcrc se n7 ipq lori w[n si zti ohun t7 w-n t7 yzn lqzy0 n7gbz kan r7.

***gb3s4 karun]un:** Ol6wad87 ni 8j7r0r0 p2l5 zw[n zk9pa l9r7 8dqnim= w[n k9 t9 d7 p3 zti l1yin 8x4wad87 arun jcjcrc zti b7 zw[n ixe w=ny7 ti xe y7padz l1yin zy2w0 8wzd87. Ol6wqd87 t[w[n s-nz lqti j1 k7 w-n o y7padz, w[n 8 t78 s[2ddq]8dqn7m- [w[n n6. W-n kzn n7 lqti ztunb=tqn 4r0 rere nipa z8szn jcjcrc k7 w[n le ba m[r7r8 ohun to xe pztzk8 l1k6n]5n]rcrc. Ol6wqd87 ran zw[n ak9pa l-w- lqti s[l3sccsc zw[n oj5xe zti ipa t7 w-n ti ko tzb7 m5xc boya g1g1 b7i 0b7 zb7 [k[tabi b7i 8yzw9. Zw[n ipa y87 lee p2l5 x7xix3 lqti xzt8ley8n f5n 8d7l3, 8bql0p0 tin5tin5, gb7gbq b-=l6 alqfcs2gbq tzb7 zw[n er3 8dqrayq m7rzn p2l5 [m[d3 kan tzb7 [m[][m[. Z8szn jcjcrc zti 8t-j5 u r2 le4 j[b7 w7p3 8gb3s2 nqz 0 le4 xe3se, o si le s[8dqnim= cni l9r5k[l9r7 zw[n ipa w0nyi, s7b2, zw[n w[ny7 xe 3 szk9so labc b9 ti w6 kori. Zw[n =nz tuntun lqti jc 0b7 tzb7 [k[ab7 8yzw9 xe 3

s2dq/p87ya.)b7 s8 t5n l4 wo b-=l6 alqfes4gbq tzb7 zw[n er3 8dqrayq m7rzn p2l5 [m[nqz tzb7 [m[][m[, so zw[n 8r7r7 r2 gbogbo p2l5 u r2 ki o si mqa s=r= n7pa zw[n 8r4t7 zti =p= zlz rere f5n [m[naa k9 dz b7 0 s7 okun lqti sqr3 ka p2l5 [mp =5n.

***gb3s4 kefz**:)l6wqd87 szlzy3, b12 l9 s8 xztcnum- l9r7 pztzk8 bi 8hz ti cn8k== k[s7 8r7r7 8yzs-t= [w[n lqw6y[zti 8doj5k[nipa y7yan 8h6wzs7. O xe 4k5nr1r1 zlzy3 l9r7 b7 zw[n ak9pa gbogbo ti ni 8faradz lqt2y8nwq zti b7 w-n xe l4 t5n n7 8gbzm-ra b12 l-j- 8wqj5. O ran w[n l[w[b7 w[n xe le n7 zzy0 2r7 [kan lqti mu 8r8nzj0 w[n t2s7wqj5 ju lqti j1 k7 4r0 8lz]k[jq w[n ana 9 gba w[n l[kan t7 9 le m5 w[n 9 rin 8rinzj= 0n7 n7n5 ewu. Ol6wad87 k0 sz8 tcnum- b7 8padzb=s7p0 zg- ara w[n ti se jc dandan to zti b7 y7yzn lqti k[j5 8jz s7 z8szn nqz xe k9 ipa t9 p= t9 lqti f5n w[n l9kun t7 9 le4 m5 bor7 zw[n 8doj5k[t7 9 r[m- z8szn nqz. El3y87 le 4 wq s7 8m5xc n7pa w7wq zti f7f7 zw[n zxzyzn 8t9j6 t7 9 dqraj6l[s'oju 8xe j6 s7sinmil3 zw[n 8gbzgb[zt2y8nwq.

Rir[zti s7s=r= 8w5r7 s7 zw[n ak9pz lqti xzm5l0 8gboyz zti k7 w-n s8 fzy4 s7l2 f5n 8faram- to ni 8tum= lqtzr7 zw[n 8x1 x7xe w[n, ti o f5n ni znfzzn7 lqti xoj5se to p3ye f5n 8t-j5 ara w[n, zti pzqpzq, k7 w-n s8 gbqrad8 lqti gba 8r7r7 z8szn jcjcrc c w[n b77 9 ti wq, nipa x7xe b12 "Y90 8bzn5j1 c w[n pada si ol5bor7 8x1gun ti o s[8yz w[n axeyori" (Frankl)

M7m5 Xqz $k- Wq S0pin

i. Zw[n ol6k9pa n7 lqti se 8j7r0r0 l9r7 zk0r7 2k- zti b7 9 xe j1m- 8r7r7 w[n.

ii. Mo ran zw[n ak9pz l3t7 lqti ka iwe: "*wqd87 $n8yan f5n *lum="

iii. Ol6wq d87 b34r4 b7 =r= 8r0ye tzb7 8b33r4 bq wz k7 2k- nqz t9 wq s7 8dqnud5r9

iv. Ol6wqd87 m5 sqz 2k- nqz wq s7 8dqnud5r9 b7 9 xe fi 8dup1 c r4 hzn s7 zw[n ak9pa f5n w7wa a w[n zti lqti j1 kqn m= p3 0un f'oju s-nz lqti r7 w[n n7 sqz 2k- t9 ê b=. (rqn w[n l3t7 [j- zti zk9k0 2k- fun sqz t9 ê b=.

Sqz @k- Kcta

K9k9 @k-: $r0çgbz Ztin5dq, Ewu t9 le szk9bq, *Tum= *dqnil1b7 p2l5 *bqmu s7 Z8szn Jcjcrc

$r0çgbz: B7 2k- sqz y87 xe n l[s9 pin, ak9pa yc k9 le 4

i. Szlzy3 8tum= z8szn jcjcrc zti zw[n z8m8 r2

ii. Daruk[zw[n ewu t9 r= m- jcjcrc zti [nz lqti d4nz w[n

iii. Se 2k5nr1r1 zlzy3 k9k9 =r= nqz zti zw[n 8x0ro 8dqnil3bii rc

Ix1]x7xe:

***gb3s4 k7nn7:** A k7 zw[n 9l6k9pz kqqb- s7 ibi 2k- naa

***gb3s4 keji:** Ol6wad87 b34r4 8m= 8xzqj5 l-w- zw[n ak9pa n7pa z8szn jcjcrc, zw[n ewu t9 r=m[[zti zw[n zzm8 z8szn fun on7r5ur5 z8szn jcjcrc.

***gb3s4 kcta:** Ol6wad87 szfikun 8m= zw[n ol6k9pa l9r7 z8szn jcjcrc, o szlzy3 ir5f1 z8szn t7 jcjcrc jc.

A le szp4j5we z8szn jcjcrc p2l5 zp=j6, on7k7qk7q 8dzgbz t7 0 n7dal1nu, 8yapa zti 8tznkql2 alagbeka ohun ajeji lqg=- ara t7 9 l4 bor7 t9 s8 le szb6d3 fun zw[n 4rojz zsopo n7n5 ara. Boya nipa zjcb7 tabi 9 wqy3 lqtzr8 agb4gb4 t7 z ç gb3, z8szn jcjcrc n77 xe p2l5 8x2k7s1 t7 g78n8 ti n x3szk9so 8m5dzgbz s12li xe n p= si n7n5 zg9 ara le pa bi zw[n 4t- ara t9k6 xe ê xix3. *dqm= t9 farahzn j6l[n7n5 or7sir7si z8szn jcjcrc ni z8kqpq 8dzgbzs9k34 zti 8k9raj[p= zw[n s12l8 to o xix1k7x1. Oj5l9wo s12li mqa ê xix3 g1g1 b7 zgb3kal2 inilara xe lzq l2 n7 d33d4 8r5f1 s12l8 gan]an (Aw[ara, 2j2, [p[l[). Zw[n oj5l9w9 s12l8 y87 le4, p7n, w-n 9 gb09, k5 w[n s8 xe pzs7pzzr= ara w[n d72di2. Bi s12l8 zr6n jcjcrc ti ê dzgbz yzt= s7 b7 ti tara ti ê dzgbz. Bi 2j2 ti n xzfzn7 f5n zw[n 4r0jz ara t9 k6 ba bzj1, d7p0 k7k5, 2j2 z8szn jcjcrc mqa ê dzgbz si t7 9 s8 di s12l8 7d8bzj1 ti o si n dzgbz si geerege, ni =nz z8t- w[n 0 si n7 gb9 b9 ti yc. Zw[n s12l8 w=ny7 le dzgbz s9d8 k7 w-n di 2w5 t9 n7 4t5t5 n7n5 d7p0 zw[n oj5l9w9 zpap= s12l8 t7 9 s8 gba gbogbo ara (Nezu, Greenberg and Nezu, 2010) Z8szn jcjcrc l4 jc jqde n7 =p=l[p= 4yz p2l5 zy[r7s7 or7sir7si jcjcrc, n7gbz m7rzn 9 le tzn kqzkiri gbogbo êpas2 2j2 zti

zw[n 2yz [gb1. A xe zk[[lc zw[n ewu t7 9 le szk9bq f5n z8szn jcjcrc zti zlzzy3 l9r7 w[n. (Oçfz zk9bq j1 zw[n 4rojz b5bur5 t9 le m5 k1n8k==kan szgbqk0 z8szn). Ohun t'aw[n 44yzn ê s[l9jooj5m- n7 ipa gb09g8 l9r7 zfin5r0 zti zf[kznr0 t9 s8 padz mqa n pa 8gb3s2 cnib12 lqra.
N7n7 8dql1bi lqzrin zw[n alq8san jcjcrc n farahzn n7gbz ti alq8szn fi 4r4di ok6nfz z8szn t9 ê se w[n sun ara w[n l9ri ohun t7 w-n ti xe scyin tzb7 xaaju, agb4gb4 tzb7 zw[n cnibi]cni lqy8kq z w[n. Zw[n kan fi z8szn naa sun zm5wq lqt=d= zw[n alqgbqra okunkun tabi 9 l4 j1 b5bur5.
***gb3s2 kcrin**: Ol6wqd87 szlzy3 fun zw[n ol6k9pa wipe n8gbz t9 ti j1 p3 a ti m[zw[n ewu t9 le szm5wq z8szn jcjcrc, k0 t- f5n alqiszn lqti fi ip0 z8lera w[n sun zw[n 4r4d7 t7 k0 n7 2r7 8p8l2.

M7m5 Xqz $k- Wq S0pin

i. Zw[n ol6k9pa n7 zçfzn7 lqti b4r3 8b34r4
ii. Zw[n ol6k9pa n7 lqti salaye 0hun t7 z8szn jcjcrc j1, zw[n t9 ê xzk9bq, t7 z8szn jcjcrc j1, zw[n ohun t9 ê xzk9bq lzàà8 zti zpccrc t9 ê xzfihzn cn7 lqzr6n y87.
iii. Ol6wqd87 xe alaye n7k5k5r5 l9r7 k9k9 2k- ohun t9 ê xzk9ba fun z8szn jcjcrc, zzm8 z8szn zti d7dqracni lcbi lqzr7n zw[n alaisan jcjcrc
iv. Ol6wqd87 d5p1 b12 l9 kan sqqrq si zw[n ak9pa fun 8f[w-sow-p=
v. W[n ran zw[n ak9pa l3ti [j- zti zk0k0 fun, 2t0 2k- sqz t9 ê b=

Sqz @k- Kcrin

K9k9 @k-: Itum[8s4wq d87 Ara Cni, 8lznz zti 8lznz xixe Iwqd87 Ara]Cni ni Zjosep= p4l5 D7dqnil1bi lqzr7n Zw[n Alq8szn Jcjcrc

$r0çgbz: B7 2k- sqz y87 xe ê par7 l[, zw[n ak9pa y9o le4:

i. Szfihzn =yc e w[n n7pa [r[t7 a p4 n7: "Is4wqd87 Aracni

ii. Lo zw[n 8lznz 8s4wqd87 aracni lqti m5 zd7nk6 bq 8gb3ay3 8dqnil1b7

iii. S= zw[n 8lznz x7xe 8wqd87 zti 8l0 w[n b7 akoko bq t9 f5n un.

Ix1]x7xe:

***gb3s4 k7nn7:**

(i) Ol6wqd87 k7 zw[n ak9pz kqqb- p2l5 zy1s7, 9 s8 yc 8lera w[n w=

(ii) Ol6wqd87 xe zt5ny2w0 8w3 e: "*wqd87 4n8yan f5n 8tum= p2l5 zw[n ol6k9pq. Zw[n ol6k9pa n7 lqti m5 iw3 nqz wq s7 8gb3l3w=n b7 ol6wqd87 xe szlzy3 s7wqj5 s7i l9r7 k9k9 o r4. (s8 xe zsop0 rc p= m- 8dqs7 l[[l[[y87, 8l0 zw[n ol6k9pa

(iii) Ol6k9pa szlzy3 l3k6n]5n]r1r1 or7 =r= nqz p2l5 zw[n ol6k9pa

*s4wqd87 t5m= s7 it-j5 ara n7pas2 7tum=. (j1 8t-j5 ara t7 9 ran zw[n 44yzn l-w- lqti mq]d7nêk6 ba 7bzn5j2 ni zk9k0 zw[n 8lzk=jq t9 lqgbqra n7pa x7xzm5l0 8m= zt0ye aracni nipa 8wz, 8r7r7 zti ixe s7 gbogbo 9 j1 it-j5 ti a piyam[f5n m7m5 zd7nk6 bq zw[n 8r0n5 zba d8 zti 8bzn5j1 t9 n77 xe p2l5 z8szn jcjcrc lqti j1k7 alq8szn ni zfoj5s6n l9r7 8xepztzk8 p7p4s4, n7n7zsop- p2l5, 8r7r7 zti gb7gb9kzn n7 zk9k0 z8lera. $y7 ê ram k99wq l-w- lqti xzxzyzn ohun t7 9 w6 w-n l-j- 7wqj5.

*s4wqd87 aracni j1 igbese 8szlzy3 t2m7 s7 7pa 8f0yem= l3r0 zti n7 8xe t7 9 sinmil3 8gb3l3w=n [m[4n8yzn g1g1 b7i s7szwqr7 8tum= zti m7m5 4n8yan n7 8gb3ay3 8tum=.

*s4wqd87 ara]cni gb44r0 p3 2mi eniyan j1 ol6szk9so 4t0 8lera j6l[t7 9 s8 le j1 g1g1 bii 8p8l2 fun 8p0çgbc zti agbqra fun itum[8gbqy3 zti 2m7. Zgb3kal2 nqz duro l9r7 8p8l2 p3 zw[n 2n8yzn n ni 8rus9k4 [kqn n7pa "Y90 s7 *tum=". T77 xe 8rus9k4 t7n5 lqti szwqr7 8tum= si 2mi. (s8 j1 8gbzgb- Frankl bqkanqz pe:

8dzgbzs9k4 zti 0m8nira lqti yzn". Zw[n 8xzà5l0 m1ta gbqj8 t7 8x4wqd87 ara]cni ni: 0m8n8ra lqti yzn 0m8nira s7 8tum= zti 8tum= s7 8gbqy3 j1 zw[n ohun pztzk8 si 8gb3 ay3 t7 9 n7 8tum[.

***f1 s7 *tum=**: T5m= s7 4r0kz 8r6soke gan]an n7pa w7wq 8tum= zti gb7gb3 ay3 t7 9 n7 8tum= n7pa w7wq 8tum= zti gb7gb3 ay3 t7 9 n7 8tum= b7 7p0 t7 9 wz k0 til2 bqni lqra mu, tzb7 f5n zrun t9 ê xe alq8szn n7n5 zg- ara. El3y87 xe pztzk8 fun 8padzb0s7po l1y8n aare ati 8gb3 ay3 zlqqf7z.

***tum= *gbqy3**: Le4 di m7m= t7t7 en8k==kan fi mi e4m7 8kcy8n. N7n7 0ye 8tum= ay3 j1 8pil2s2 8rus9k4 fun 8gbqy3. Ni g1g1 ti 2nik==kan m[8rus9k4 fun 8gbqy3, 1ni nqz ti b2r2 s7 n7 sapq lqti mu 8l3r7 zw[n zm5ye fun 8gbqy3 t7t7lq7. *tum[ohun t'qy3 j1 le4 dim7m[n7pas4 zw[n ohun t7 9 ê l[n7n5 zgbqlqay3 b7 zw[n 4n8yzn ti ê n7 8bqracnixep=.

N7 t7 z8szn jcjcrc, cn8k00kan ê xaqp[n lqti k9ju]w=n, l9r7 zw[n 8gb3s4 8t-j5 u r2 k8 w-n s8 j=w- zw[n 4r0 8dqnil1bi. $t0 *x4wqd87 Ara]Cni gb44t0 p3 b7 4n8yzn bq le xzwqr7 k7 9 s8 m5 8l3r7 8wqsqy3 xc, o t5m= s7 p3 k0 wo zw[n 8j8yz a r2 gbogbo. N7pas2 8gb3l3 w=n m1ta gb09g8 t8 z ê gbz xzwar7 8tum= (x7s2dq, x7xzdqnw0, zti 8h6wzs7 n7n5 8x4wqd87 ara]cni. Zw[n alq8szn jcjcrc ni agbqra lqti ni 8d5r9 ak[ni zti lqti x4y7padz 8j8yz s7 8pel2 zseyor7 4n8yzn t7 9 ga j6. *gb3ay3 9 wz q n7 8tum= d3bi w7p3 8j8yz 9 dzb77 8gb3ay3 zlqqfiz.

***gb3s2 kcrin**: Ol6wqd87 j7r0r0 zw[n 8gb3s2 c 8s2wqd87 ara]cni n7 8bqmu p2l5 d7dqnil2b7 lqzr7n zw[n alq8szn jcjcrc. *x4wqd87 ara]cni j1 8f0yem= 8x4t9j5 t9 n77 xe p2l5 8gb3s4 2m7 t7t7 d3 gb0çgb0 8x0r0 t7 9 mqa ê m5 k7 zw[n e4yzn m[r7r8 oj5se fun 8wzlqzy4, gba 0m8nira k5r0 n7n5 8p0r56ru [lzn zti k7 w-n xzwqr7 8tum= zti 4r4d7 ay3 e w[n. Cni t7 9 xzgb3kal2 7x4wqd87 ara]cni, Frankl, s[n7pa 8x2l2 n7n5 4y7 t7 cni t9 n7 z8szn jcjcrc ti n5 s[8f1 zti wz lqzy4 n6 t7 9 s8 y[r7 s7 8j8yz p2l5 8nira lqtzr7 p3 9 s[8r4t7 n6 x6gb-n. (padz xzxey9ri l1y8n t7 9 r7 8tum= s7 8gbqy3. (s8 gba 8lzk[jq r2 p2l5 r2 p2l5 8gboyz. L2y8n 4y7, o tiraka lqti gbz p2l5 8gboyz. L1y8n 4y7, o tiraka lqti gbz p2l5 zw[n ohun zm5l0 lqti doj5k[8t-j5. O oadz gbz w7p3 8rora o gb[d= j1 8bzn5j1 s7 alq8szn b7 w-n bq le pinnu

p3 8tum= 8nira a w[n j1 4r0çjz t9 xe pztzk8 t9 s8 lqgbqra fun 8s0diw=n lqti f'ara da 8p0r5ur6 [kzn an w[n.

Ol6s4wad87 szlzy3 f5n zw[n ol6k0pa p3 ol5bor7 9m8nira 4n8yzn ni ipq lqti yzn 8hz t7 a k[s7 8x0rok7x0ro, koda, k9 j1 4y7 ti o kor0 b5 jogbo.

*gb3s4 kar6n]5n: Ol6wqd87 xzlzy3 zw[n 8lznz 8s4wqd87 ara]cni p2l5 zw[n ol6k9pa p2l5 l8l0 o w[n.

IY_KZNPADZ L(R& *L#PA KAN S&)M&RAN TI O DARA: B7 4n8yzn bq n7 zfoj5s6n 9xe3xe s7 8x0ro tzb7 zzm8 z8szn p2l5 k7kank7kan w7p3 w-n ê dq zfoj5s-nz 8f0yz s7l2 t7 9 s8n m5 k7 8s0r0 tzb7 zzm8 z8szn nqz o bur5 s7. *lznz 8y-kznpadz cni padz ê xix3 f5n x7szt5nxe s7 zk7y4s7 on7bzqrz lqti p3 k9 gb-kzn k5r0 n7 zw[n zk9l3yz 8x0ro tzb7 zzm8 z8szn t7 ê bqa f7nra k7 9 sin7 zfoj5s6n tuntun d7p0 s7 ohun t9 jcm- zw[n ohun 8runil-kzns9k4 8gb3ay3 8tum= ara]cni. Zbqjqde ipq a r2 j1 zd7nk6 s7 zfoj5s6n 8foyz t7 9 n7 8bqsep= p2l5 zzm8 z8szn tzb7 8x0ro t7 8b34r4 dql3l9r7 ztibqkanqz m7m'zd7nk6 ba zzm8 z8szn tzb7 8x0ro =5n gan]an.

Zw[n *lznz *y7nil-kznpadz sel=di s7 zp=j6 8farahzn, ti a le szp4juwe gcg1 b77 zp=j6 zfoj5s6n tzb7 8faracnikin 8x0ro 0un zzm8 z8szn t9 le4 y[r7 s7 abur9 tzb7 w7wo ay3ara]cni tipqtipq. A mqa gb3 [kzn on7t=h5n k5r0 pqtqpqtq lqra 8x0ro tzb7 zzm8 z8san an r2 t7 9 s8 dar7 i r2 s7 =d= cl0m7rzn tzb7 s7 agb4gb43 8w5r7 (Frankl, 2004). Lukas (1998) szp4j5we zw[n 8lznz znte1l1 g1g1 b7 8gb1s2 m3j8: 4k7nn7] "zzm8 8dqd5r9 ni w[n 9 f5n oêibaqrz lqti pa 8r0n5 t8. *gb3s2 kej8 ni zzm8 8yapa" 4y7 ni lqti pzzr= =nz 8r0n5 44yzn n7 8ta ara lqti gbqj5 m- 8tum=. Fifi ara]cni j8n f6n oj5xe kan pqtqpqtq a mqa m5 ni gbzgb3 ara wa, ka k9 g7r7, y9o s8 m5 wa xzsey[r7 l9r7 ohun to se pztzk8 w-n r[zw[n ol6k9pa lqti m-kzn w[n k5r0 lqra 8x0ro t9 f[b7 cn7 lqgbqra j6w-n l[, k7 w[n s3 l3pa ohun to nitum= t0 s8 t9b8. Ol6wqd87 j1 k9 y3 w[n p3 zfoj5s8n w[n k0 gb[d[pzp=j6 lqra zzm8 z8szn to n se w[n s7 8palqra okun]un w[n.

$r0çgbz F7f7 +nz Zbqy[Xzkoso Ew6

*lzn f7f7 =nz zbqy[xzkqso ewu jc l7l0 l'qt[un Frankl ni 1929 fun 8gbz zk-k- ir5 r2. O si d5r9 l9r7 4roçgbz j7j8nz]si]ara]cni nipa 8xzm5l0 8lznz zr7ntzk8t8 tzb7 l1k==kan n7pas2 ohun t7 0 m-gb-n wa. F5n zpccrc, w[n le n7 k' 9n7bzqrz o fara q l2 f5n ohun ti 9 d1r6 bzq j6l[n8pa r7r= 9 (p2l5 2r7n tzb7 zs[]r3g43) lqti xe ohun t9 l4 d1r6bzzyan j6l[. Niti cni t9 ê ni 7r7r7 8kal6 2r6 t9 ga t9 s8 ê b2r6 zti n7 zr6yn][kzn, w-n 9 n8 7 k7 ol6bqrz 9 s[f5n ara r2 pe: "Mo f'oj5 s-nz lqti n7 zr6n][kzn t7 9 dqra l9n87, n7 s7xub5 s7l2 zti 8fara cni x2s7n". $r0çgbz fifi =nz zbqy[szk9so ewu ç dojq 8jz k[ewu 8f[kznsi 4r6 ti o s[gb6ngb6n eru tzb7 8jaya d0fo. *x4wqd87 ara]cni mqa ê m5 8gboyz 2r7n zr7ntzk8t8 bi ipa 4r0njz to fiyat= hzn s7 8y7pzdz 8wz8lznz (Frankl 2004). @r7n]zr7ntzkiti j1 ohun 4l0 fun 44yzn t9 ê k9pa gb09g8 l9r7 zzm8 z8szn, lq8 7 ze s3 ol6bqrz. Ni x9k7, 4r0 ztin5da b2r2 lqti ibi f7f5nra]cni j8nnz s7 zzm8 z8szn ti ê xe ni. Nipa liloo rc, y9 b87 awzdz a o s8 fi ohun t7 ê jqnilqyz r1r8n]7n. $y7 y90 k9wa y[k5r0 n7n5 ewu 8bzn5j3 zti zin7r4t7.

W-n ru zw[n ol6k9pa soke lqti ri 8x2l2 kan t7 9 bur6 jq7ju, t9 s8 t5n f'cni scsin bqkan nqz, b12 l9 dzb7 ohunt7 0 le4 gb- zt5nxe x6gb-n l-w- lqti m7ra]cni j8nnz zti lqti jqra]cni gbz. Lqti m7ra]cni j8nnz s7 8s0ro t9 ê bqni f7nra, 4yzn n7 zr7dqj5 zti 4r0 on6 debi wipe 8x0ro nqz k0 t5n gb3 onit-h5n n8 m-. N7n5 y7ycra]cni, n7gbz t7 44yzn le m- b=- pqtqpqtq k5r9 n7n5 8s0ro z8lera, oêt-5n n7 0m8nira zti yan 7hz t7 9 k[s7 8x0ro =un, 8gb3s2 zti xe zt5nxe s8 le wqy3.

***y7padz *wa**: El3y87 szfoj5s6n zti xzy7padz s7 8wz, bo xe tako s7szy7padz 4r0 eni. Ol6wqd87 r[zw[n ak9pa lqti p87ya 7hz tuntun s7 8x0ro l[[l[[y87 lqti rzn w-n l[w[lqti szk9so ip0 o w[n dqq dqa si.

***takor=s[El1gbccgb1**: El3y87 j1 4r0çgbz 8r9nilqgbqra t7 mqa ê ran on7bzqrz l-w- lqti xzwqri zw[n ohun 4l0 t7 w-n n7 lqzr7n ara w[n t7 w-n le l0 lqti bor7 8doj5k[[w[n gbogbo. *lznz y87 fzzy4 f'9n7kqluk5 lqti m= w7p3 8dqh6n si 8x0ro onikqluk5 ê bc n7 in5 w-n, s5gb-n 9 k6 s-w- on7kqluk5 lzt7 szwqr7 i rc. Ol6wqd87 t3t7s7l2 t7n5t7n5 s7 zw[n 4r0 buburu ol6k9pa bcc lo t-kz zw[n k9k9 =r= tzb7 zw[n =r= t9 le m5 =nz zbqy[wa. (xe

8t-n7 f5n w[n b7 w-n xe le piiya =nz m7rzn s7 b7 a ti7 ron5. $r0çgbz a r2 ni lqti m'qy87padz bq zw[n 4r0 b5bur5 zti lqti pil2 zw[n or7sir7si =nz z q gbz ron5.

***gb3s4 kcfz**: Ol6wqd87 j7r0r0 p2l5 zw[n ak9pa, bi zw[n 8lzna naz se l4 j1 l7l0 s7 ohun t9 ê sclc gan]an.

P7pal2m- @k-

(i) Zw[n ak9pa n7 zêfzn7 lzti b4r4 8b34r4

(ii) Zw[n ak9pa n7 lqti szp4j5we ohunti 8x4wqd87 ara]cni j1, zw[n 8lznz a n r2 zti b7 w-n xe l4 l0 w-n p2l5 8bqmu s7 8doj5k[[w[n l-w-l-w-.

(iii) Ol6wqd87 xe zlzy3 zk9p= is1 gbogbo fun sqz 2k- naa, bcc lo gb9s6bz kqre fun zw[n ak9pa fun zk9k0 zti ipq t7 w-n lo

(iv) {j- zti zk9k0 fun sqz 2k- t9 ê b= ni ol6wqd87 s'zlcnum- [n r2

Sqz @k- Kqr6n]5n

Zk0r7 @k-: Zw[n ohun t9 j1 Gb0çgb0 *p8l2 f5n $t0 *s4wqd87 Ara]Cni s3 *bqmu P2l5 D7dq]ra Cni L1bi

$r0çgbz: B7 4t0 2k- saa nqz ti ê par7 l[, zw[n olukopa yc kqn le:

(1) Szm5l0 0ye e w[n nipa =pqk6t2l2 f5n 8x4wqd87 ara]cni, k7 w-n s8 l0 w-n f5n 8szk9so 8dqnil1bi.

Is1]S7xe

Igbese k7nn7: W-n k7 zw[n ol6k9pa kqzb= s7 sqz 4t0 2k- tuntun.

***gb3s4 kcj8**: Zw[n ak9pa yqra xe zs[p0 ix1]x7xe ti sqz t9 k[jq p2l5 8t-ni lqt=d=[ol6wqd87.

***gb3s2 kcta**: Ol6wqd87 szlzy3 zw[n =pqk6t2l2 8s4wqd87 ara cni s7 zw[n ak9pa. *s4wqd87 Arz]Cni p7n s7 =na m1ta pztzk8 t7 9 n7 ixe p2l5 ara w[n. *d7 ni p3 [m[4n8yzn ni 8rus9ke tin5 f5n 8tum= b12ni w-n n7 zçfzn7 lqti yzn k7 w-n s8 gb3 8gb3ay3 t9 n7 8tum= n7tor7 a l4 salqbzqpzd3 8tum[n7 gbogbo =nz.

(1) **)m8nira lqti yzn**: k99wq n7 lqti x4midzgbz agbqra f5n 0m8nira lqti yzn lqti le ran qn l-w- lqti yzn b7 a ti xe e s3 s7 8doj5k[cni zti 8pinnu l9r77 ipa 8gb3 ay3 t9 bq wu ni. El3y87 ê ran 4n8yzn l-w- lqti xoj5xe, k7 w-n s8 jc zpccrc [m[l5zb7 t7 w-n le n7 zk9j[lqti yzn tzb7 j1 ol6gb=nw9 ztunb=tqn

fun 4roçgbz zti 8xe e w[n gbogbo.)m8nira lqti yzn j1 om8nira lqti wa 8tum= s7 8wzlqzy4 zti lqti yan 8r5f1 8gb3ay3 s7 8yz b12 g1g1 lqti yan 8hz t7 z q k[si z8dqnil9j5. Frankl dqbzq pe: "ol5bor7 ohun t9 k1y8n t77 xe 0m8nira to k3r3 ti a n7 gcgc b7 4n8yzn ni lqti szgb3yew0 k8 a s8 yzn 8hz zti 8wz t7 a 9 k[s7 8j8yz, k9 dz b7 9 t7l2 j1 p3 ohun gbogbo t7 7 ze omin8ra l9 ti gbz l[l-w- [wa. Z7szan jcjcrc zti 8t9j5 u r2 n fq 0d8w=n t7 9 lqgbqra, ijiya zti 8m5k5r0 lqzy4 cni l-p=l[p=m s6gb-n s7b2s7b2 e4yzn n7 0m8çira lqti yzn 8hz y90 k- s7 8r7r7 jcjcrc.

Ol6wqd87 y90 szlzy3 f5n zw[n ol6k9pa w7p3 lqti l4 bori 8gb3ay3 8dqnil1b7, w-n n7 lqti xzm5l0 okun 0m8nira lqti yzn zti lqti n7 agbzra l9r7 i r2 b12 gcgc b7 w-n ti ê dqh6n s7 ip0 t7 w-n wa l-w-l-w- it5m- t7 w-n f5n]un zti b7 w-n xe f5n]un n7 itum- si. (xe ztcnum- pe on7kqluk5 l9 n7 7 xe p2l5 ara r2 s7 zw[n cl0m7ran zti s7 zw6j= [w[n n7pa p3 k99wa le4 yan ohun t9 f3 lqti xe zxey-r7 8d6nêu ati 8lera p7p3.

(2) **Ore +f1 s7 *tum=**: Ore =f1 s7 8m[r7r8 xe pztzk8 f5n 8wzlqzy4 zti ilera. (j1 =pqk6t2l2 m9r7yq fun x7xz qr7 im=r7r8 zti gbigb3 ayc alqf7z. K0 yc k7 4n8yzn j1k7 8lzk-jq, 8r0n5 abazd8 tzb7 8p0r5ur6 znq 9 mqa t87 gb=n]=n]gb=n]9n, kzkz b12 k7 9 l3pa m7m5 8l3r7 [j- iwqj5 xe lqti l4 n7 iyel9r7 n7pq 8gbqy3. &f1 lqti szwqr7 8m[r7r7 8wqsqy3 j1 =pqk6t2l2 f5n 8w5r7 lqti xzt5nxe si 8wz 4yzn.

Ol6x4wqd87 y90 salaye y3k3y3k3 s7 zw[n ak9pa w7p3 8f1 s7 8m[r7r7 tzb7 s7 8tum= a mqq y3ni j6l[n7gbzt7 0ye 8gbqy3 bq y3 ni y3k3. Lqti le gb3 bor7 8dql1bi zti 8doj5k[gbogbo, ol6k9pa n7 lqti xe 8pinnu t7 9 jinl2 s7 8tum[8wqsqy3 e r2 t7 9 s8 f5n]un ni 8s5ra 8doj5k[s7 8j8yz z8l9diw=n t7 y9 f5n]un n7 8t2m-ra s7 8t2s7wqj5 lqti gb3 8gb3s4 t7 9 y[r7 s7 8szt5nxe oêitum[l9r7 z8szn jcjcrc.

(3) ***tum= *gb'qy3:** Ay3 n7 8tum= b12 n7 k0 d1kun zti mqa n7 8tum=. X7xe3xe lqti n7 8r7r7 tzb7 lqti x4dq 8tum= êl[b12 t7t7 di 0pin 2dq. *tum= 8gbqy3 8f8d7]m5l2 09t- p3 a le4 r7 8tum= n7n5 ohun t7 9 bur5ku j6 l[zti

n7n5 8lzk[jq t7 9 kor0. Il4]ay3 ni 8tum= n7n5 8gb3ay3 cn8k==kan lqpap=, lq7 ya =kan s-t=. Ol6wqd87 salaye pe k87 se 8tum= il3 ay3 l9 se gb09g8 b7 kii ba xe 8gb3 ay1 cn8k==kan n7 zk9k0 kan pzt9. *d7 ni p3 cn8k--kan n7 lqti xzwqr7 ohun t7 zk9k0 y87 j1 f5n]un.

Zw[n ol6k9pa gbq 8t-ni s7 zw[n ibi 8k7y4si f6n 8szwqr8 8tum= n7pz:

- 0ye cni nipa 8r7r7 il3]aye
- X7xe 0j5xe wa n7n5 ay3 ati p2l5 4n8yzn

Ol6s4wqd87 t- zw[n ol6k9pa n7pa x7xzwqr7 8gbqy3 n7n5 ip0 b77 jcjcrc xe pztzk8 s7 8gb3 ay3 8tum= n7pa s7szm5l0 [r[Nietzche t7 9 s[w7p3: Cni t7 9 n7 er4d7 lqti gbqy3 le4 farada ohunk9hun". El3y87 t5m= s7 p3 b7 ohun gbogbo t9 yc k9 f5n n7 ay3 8tum= bq kcy8n s7 ni, tzb7 t7 w-n bq ê doj5 8jz k[z8szn b77 jcjcrc, tzb7 t7 w-n wz n7n5 8nira, tzb7 8bzn5j1, tzb7 t7 w[n bq ara w[n n7n5 ip0 z8n7r4t7, n7n7 0ye 8tum= s7 8gbqy3 y90 m5 k7 w-n le dzyz k[8j8yz k7 w-n s8 p4s4 cn8k==kan p2l5 4r4d7 f5n 8wzlqzy4 lqti bor7 ip0k7p0.

*gb3s2 kcrin: K7 zw[n oluk0pa 9 s[zw[n 8gb3s2 tan ni l-kzn lqti gbe t7 y90 m5 w[n bor7 8p4nijz 8dqnil1bi n7 l7lo zw[n ohun 4l0 8s4wqd87 ara cni.

***szk9p0 @k- sqz**

(i) Ol6s4wqd87 f'azy4 gba 8b34r4 lqt=d- zw[n akopa

(ii) K7 zw[n ol6k9pa, o zw[n ohun 8xzm5l0 fun 8s4wad87 ara cni k7 w-n si szlzy3 l1k6n]5n r1r1 b7 w-n se le j1 l7l0 fun 8szk9so 8dqn7l1b7 ati zt5nb=tqn w[n.

(iii) Ol6s4wqd87 se zs[kqgbq sqz o si k87 zw[n ak9pa fun 7s1 takuntakun.

(iv) W-n rqn zw[n ak9pa l3t7 [j- zti zk9k0 fun ix1 saa t9 ê b=.

Sqz kefz

K9k9 @k-: Or7sun *tum= zti *dqnil1bi

$r0çgbz: B7 2k- xqz ti ê par7 l[, 9 yc k7 ol6k9pa le4

(1) Se 8dqm= or7sun 8tum= ki o si lo zw[n or7sun w=ny7 lqti xakoso 8dqnil1bi

Is3 S7xe

***gb3s4 k7nn7**: Ol6wqd87 k7 zw[n ak9pa 9 s8 xe zt5ny2w0 ix3 c sqz to k[jq p2l5 u w[n.

***gb3s2 kej8**: Zw[n ol6k9pa b2r2 zlzy3 n7 k7qk7q l9r7 ohun t9 fa d7dq 2bi ohun to fa ip0 t7 w-n wz l-w- s7 zw[n ok6nfz z8r7.

***gb3s2 kcta**: Oluwzd87 szlzy4 w7p3 b7 9 til2 w6 k9r7 k7 8lzkoj- 4n8yzn 9r7, 8hz t7 a k[s7 8 xe pztzk8 lqti rzn wz l-w-. ohun t9 ê xcl2 k0 n7 nkzn xe b7 k0 8tum= t7 a bq f5n]un. K9 dz n7n5 z8szn jcjcrc, a le fi 8gboyz wa han n7pa s7s[ip0 zk9k0 y87 di ohun t9 n7 8tum=.

***gb3s2 kcrin**: Ol6wqd87 s[0ye zw[n ol6k9pa d7 p5p= sii n7pa 8moye 8t5m= açq, ti l--l—zti [j- [wqj5 n7pa 8x2dqa 8xzdqnw0 zti 8xes7.

***tum= N7pa *x4dq 0hun**: Ol6wqd87 s[4r0 zw[n ak9pa di p5p= n7pa =p= 8r0n5 n w[n nipz 8tum= zti ohun 4l0 t8i se 8tum= n7pa zw[n ohun 4l0 t7 a fi dq, xax4p3 zti zxey[r7. Zw[n ohun 4l0 8x4dq n77 xe p2l5 ohun t7 a f5n ay3 b77 x7xe zxep3 ix3 p7s4s4 ix3 tzb7 s7xe ix3 rere.

***tum= N7pa X7xzdqnw0 ohun Amuyc**: $y7 la m5 lqti n5 ay3, b78 8r7r7 09t-, ewa zti 8f1 s7 cl0mirzn.

***tum= N7pa *h6wzs7**: *h6wzs7 n s[n7pa 8d5r9 o wa lqti yan 8hz t7 a 9 k[s7 zw[n 8p0 t7 0 xe3 y7padz tzb7 8yz t7k0 xc 3 p1 3 l2. On7kqluk5 n7 ore]=f2 lqti wa 8tum= n7pa 8h6wzs7 t7 9 n7 8tum=, k9 dz n7 ip0 t9 bur5 p5p=. Zpccrc el3y87 waye n7gbz t7 Frankl, cni to szgb3kal2 8x4wqd87 ara]cni ran alq8szn kan t7 k0 le bor7 ip0 0fo t7 9 bqrq r2 l3y8n 7k5 8yzw9 o rc l-w-. O xetqn lqti m[ohun t7 8bq xcl2 kqn7 p3 [k6nrin y87 ti jqde lqy3 xqqj5 8yzw9 o rc, 8yzw9 y87 ni 8bq del3 fun]un. Okunrin y87 dqh6n wipe ir5f1 ip0 b12 k7 bq buru fun ob8nrin nqz d3bi p3 8yz 8bq jc 1. Frankl xe 8rznw- f5n]un lqti xzwqr7 8tum= s7 ip0 t7 9 wz l-w-l-w- n7pa x7xzlzy3 s77 pe 8yz t7 8bq se 8yzw9 y87 n87 a ti fi j8n]7n lqt[w- [k[r2 wa. Nipz 4y7, 9 n7 lqti fara da ip0k7p0 t9 bq ara r2, k7 9 s8 s0f= [fun.

M7m5 @k- Wq s9p8n

(i) Zw[n ol6k9pa n7 zçfzn7 lqti se 8b34r4 l9r7 ohun t7 k0 y3 w[n

(ii) Zw[n ak9pa n7 lqti szlzy3 b7 w-n se l4 m5 8tum= jqde n7pa 8x2dq, xzdqn6 zti 8h6wzs7

(iii) Ol6wqd87 se zlzy3 n7 x9k7 zw[n ix1]x7xe e w[n f5n sqz 2k- b12 l[gb9s6bz kqre ak9pa lqpap= f5n 8fqrabql2 zti 8f[w-sow-p= [w[n. (s8 t5n rqn w[n l3t7 zk9k0 zti ibi 8pzd3 f5n sqz 2k- t9 ê b=.

Sqz @k- Keje

K9k9 @k-: *t-s9nz Ara]Cmo zti *w5r7 s7 *bqmu P2l5 *dqnil1bi

$roçgbz: B7 4t0 2k- sqz y87 xe ê par7 l[ak9pz yc k9 le 4:

(i) Se 8dqm- 8t-s-nz ara cni zti 8w5r7 k7 9 s8 l0 w-n

(ii) N7 8gboyz n7n5 ara w[n n7pa s7xe 8t-ni ara w[n p2l5 ero rere zti =r= rere Zpccrc: “Mo l4 lz q jq”

(iii) P7l2 zw[n 4r0 =tun n7pa z8szn jcjcrc, se 4t0 oun 3r4d7 f5n on7 zti [j- [wqj5

Ix1]X7xc

***gb3s2 k7nn7**: Ol6wqd87 lu zw[n ak9pa l-g[cnu f5n 8faraj8n s7 4t0 2k- nqz t9 s8 k7 w-n kqzb=

***gb3s2 k3j8**: Ol6wqd87 se zt5nxe 4t0 2k- sqz to k[jq p2l5 zw[n ak9pa.

***gb3s2 kcta**: Ol6wqd87 szlzy4 8tum= ohun t7 8t-s-na ara]cni jc zti pztzk8 r2. *t-s-nz]ara cni n77 xe p2l5 8szm5l0 =r=]ara cni lqti dar7 tzb7 szk9so 8wz.

Zw[n ol6k9pa gba 8t-ni lqti lo zw[n 8t-ni w=ny7 lqti dar7 tzb7 szk9so 8wz.

Zw[n ol6k0pa gba 8t-ni lqti lo zw[n 8t-ni w=ny7 lqti b0 r7 8dql1b7.

1. **D7dq *s0ro M[**: *x0ro nqz (Z8szn jcjcrc) ti j1 ohun t7 a dqm= p2l5 zw[n ohun t9 ê xok6nfz a w[n.

2. **$t0**: $t0 8t-j5 8f0yem= zw[n ohun t7 9 r= m[on.

3. F7fara m- zti s7szk9so zw[n 8s0r0 t9 xe3xe k3yzn 9 bq pzd3

***gb3s2 kcrin**: Ol6wqd87 j1 k7 zw[n ol6k9pa 9 m= p3 n7gbz t7 w[n bq m’-kzn k5r0 ni zw[n ohun t9 fz 4r4d7 z8szn t9 ê se w-n, w[n o ni 8rus9k4 lqti t4s7waj5 n7n5 8t-j5 n w[n.

M7m5 @k- Wqs9pin: (1) W-n ru zw[n ol6k9pa s9k4 lqti m5ra w[n dzgbz p2l5 8xzm5l0 [r[8t-s9nz ara cni ki w[n s8 n7 8w5r7 s7 7 lqti k[j5 8jz s7 zr6n jcjcrc nipa n7n7 8tcram- 8t9j5 ara w[n ju lqti fzy4 fun 4bi.

(ii) W[n gb9s6bz kare f5n zw[n ak9pa fun 8t1t7s7l2, 8k9pa zti 8f[w-sow-p=

Sqz @k- Kcj[

K9k9 @k-: S7szw0t5nw0 Gbogbo, *szk9so Zw[n $s8 *wqd87 ati *dqnud5r9

$r0çgbz: B7 2k- sqz y87 xe ê pqri l[, 9 yc k7 zw[n ak9pa lee:

(i) S[n7k5k5r5 zw[n [gb-n ztin5dq t7 w-n ti n7 lqti 8gbz t7 w[n ti b2r2 8dqs7 zti b7 9 xe rzn w-n l-w- n7n5 8szk9so 2bi

(ii) S[s7 4s8

Ix3 S7se: W-n k7 zw[n ak9pa kqzb=, b12 s8 7 w-n gb3 =s6bz rzçd2 f5n w[n lqti r7i dqj5 p3 zw[n par7 4t0 naa.

***gb3s2 kej8**: Ol6wqd87 szgb3kal2 8pele 8takor=s[p2l5 zw[n ak9pa lqti s3 8f7d7m5l2 ipa t7 8dqs7 nqz n7. (szm5l0 zw[n 8b34r4 w[çy7 lqti m5 iranti oji tzb7 4s8 wa' s7 8rqnt7.

(i) Bqwo ni 7r7r7 i 2k- yin xe r7 p2l5 b7 c ti x e lzq k[jq f5n =s2 m1j[s1y8n?

(ii) đ j1 8yzt= kankan ti bq b7 c xe ê wo 8gb3 ay3 e y7n zti 8r7r7 z8szn jcjcrc l1y8n t7 c ti n7 8r7r7 zw[n 8lznz gbogbo?

(iii) Nj1 o n7 8m0lqra b7 cni t7 0ye ip0 z8l4ra r2 y3 s77 zti p3 lqti szm5l0 8m= ti o ni fun 8szk9so ailera nqz?

(iv) K7nni zw[n 8r4t7 8 rc f5n [j- =la?

***gb3s2 kcta**: Gbogbo zw[n is3 sqz t9 ti k[jq ni s-n fcnu bz kqr7kqr7 lqti r77 dqj5 p3 0ye 8dqs7 nqz k5n dqadqa.

***gb3s2 kcrin**: W-n se 8szk9so zw[n 4s8 8wad87 gbogbo.

***gb3s2 kar6n]5n**: Ol6wqd87 d5p1 l-p=l-p= l-w- zw[n ak9pa lqpap= f5n 8f[w-sow-p= n7 gbogbo zk9k0 4t0 2k- nqz zti k7k9pa n7n5 2k- nqz.

M7m5 @k- Wa's9pin:

(i) W[n r[zw[n ak9pa lqti so 4r0 8kcy8n tzb7 4r0çgbz t7 w-n n7 l-kzn

(ii) W-n r[zw[n ak9pa lqti szm5l0 zw[n [gb-n ztin5dq t7 w-n ti szk9jo lqti 8gbz t7 w-n ti b2r2 2k- nqz l1k6n]5n]r1r1.

(iii) K8 zw[n ak9pa k7 9 fi s-kzn k9k9 =r= t7 9 wip3: “Cni t7 9 n7 4r4d7 lqti gbqy3 le4 faradz b9 ti w6 ko’r7” (Nietzsche) ati pe “A 0 le szk9so ipa t7 at1g6n t9 fc wq, sugb[n a l4 szk9so ohun t7 a 9 fi zt1g6n nqz xe n7n5 8l3pa wa”

(iv) Ol6s4wqd87 m5 2k- nqz wq s7 8dqnud5r9 pqtqpqtq b7 9 xe ê k7 zw[n ak9pa f5n k7k9 7pa pztzk8 n7n5 8bqpzd3 naa. (s8 t5n m[r7r8 zp-nl3 zti znfzn7 j7j1 alqbzp7n]7n n7n5 8tzn zw[n akopa nqz.

IGUN *SZDQNW) KEJ*

***F)YEM+ *XZT%NXE SI *DQNIL!BI LQZRIN ZW{N ALQZR^N JCJCRC**

Zw[n Ohun $l0 F5n *l3pa: Ol5bor7 8l3pa f5n 8s4t-j5 nqz ni lqti szfik5n okun zw[n zlqzr6n jcjcrc lqti szk9so 8dqnil1bi zti p2l5 8x0ro 2d6n [kzn t0 so m- [n n7pas2 8szd7nk6 nipa 8m=.

Sqz k7nn7

K9k9 @k-: *szfihzn Gbogbogb0, *dqnil1k=- Zpap= ati *szk9so Zy4w0

$**r0çgbz**: B7 2k- sqz nqz ti ê wa s9 pin, ol6wqd87 yc k9 le 4:

(i) Szgb3kal2 =nz 8wqd87 to gb[ngb9 t7 9 bq zw[n ol6k9pa mu

(ii) fun zw[n ol6k9pa n7 8dqnil1k=- n7pa 8tum= zti 8gb3s2 8wqd87 zti 8toj5 z8lera.

(iii) Se 8szk9so ohun 4l0 zy4w0 lqti gbq 4s4

Zw[n Ix1 S7xe

***gb3s2 k7nn7**: Ol6wqd87 k7 zw[n ak9pa kqzb= si ibi 4t0 nqz. O sqf8hzn ara r2 zti zw[n am5gbql1gb21.

***gb3s2 kej8**: Ol6sewqd87 f8d77 zjosoy3p0 m5l2 lqzr7n zw[n ol6k9pa zti 0un alqra. (se 4y7 n7pa s7szfihzn ol6wq d87 zti zw[n ol6k9pa. (rii dqj5 pe f99mu f[w- s77 j1 at[w[b[f5n zr7dqj5 ati 8f8d8m5l2 zw[n ti o k9pa.

***gb3s4 kcta**: Ol6s4wqd87 p4s4 zpap= eto nqz. (szlzy3 zw[n ohun 4l0 8l3pa, 4r4d7 zti zw[n zçfzn7 t9 xe 3 bqpzd3 l1y8n 4t0 nqz. W-n fi dq zw[n ol6k9pa l9j5 pe zs7r7 w[n y90 j1 zx7r7 b7 4t0 nqz xe ê l[zti b7 9 bq par7. W-n fi dq zw[n akopa l9j5 p3 4t0 nqz y70 m5 w[n n7 8lznz 8r0n5 tuntun t7 y90 m5 kqra w[n le s77. W-n se ztcnum- 8se pztzk8 w7wq d33d3 s7 ibi 4t0 naa n7tor7 y99 xe w-n lqçfzn7 to p[.

***gb3s2 kcrin**: W-n j1 k7 zw[n ak9pa m= dqj5 pe 8pele m1j[0t[=l= ni 8dqs7 nqz ni f5n wqkzt7 k==kan. Zt'ak9pa zt'as4wad87 fcnu ko s7 8gbz zti ak9k0 sqz 2k- t9 ê b=.

***gb3s2 kar6n]5n:** Ol6wqd87 zti zw[n ak9pa j[n7 zs[y3p= zlzy3 l9r7 zw[n 8lznz zti ofin t9 r= m- 8wzd87 nqz. Ojuse ti ol6wqd87 ê reti lqt=d= zw[n ak9po ni 9 szlzy3 l1k6n]5n]r1r1.

***gb3s2 kcfa**: Zw[n ohun 4l0 8wqd87 (8gb3l3w=n 8dqnil1bi, 8gb3l3w=n zt7l1y8n zw6j=. $t0 *szk9so *lera Ara Cni) ni w-n xe lqlzy3 s7 zw[n ak9pa p2l5 8t-ni t7 9 p3ye lqt[w- ol6wqd87 zt'zw[n am5gbq l1gb21 c r2.

M7m5 Sqz @k- Wq S9pin

(i) Ol6wqd87 se zlzy3 e sqz 2k- n7 s9k7

(ii) (xe zpap[ck[sqz t9 ê b= n7 s9k7

(iii) W-n k7 zw[n ol6k9pa fun 8f[w-sow-p[zti zk9k0 o w[n

(iv) (l6 w-n l-g[cnu 9 s8 r= w-n lqti p3j5]p3s2 s7 ibi 2k- sqz t9 ê b[, n7gbz t7 9 rqn w[n l3t7 [j- zk9k0 zti ibi 8pzd3 sqz 2k- t9 ê b=.

(v) Ol6wqd87 m5 8pele 2k- wq s9pin

***pele Sqz Kej8**

K9k9 @k- Z8szn Jcjcrc, Ohun t9 le Fzq *tum= *dqnil1bi N7 Zj[sep= Z8szn Jcjcrc

$r0çgbz: B7 2k- sqz nqz ti ê wa s9 pin, zw[n ak9pa yc k9 le4

(i) Szlzy3 8tum= z8szn jcjcrc zti zw[n zzm8 rc

(ii) dqr5k[d72 n7n5 zw[n ohun t9 le fz q zti zw[n =nz t9 le gbz d4nz an r2

(iii) Szlzy3 l1k6n]5n]r1r1 zgb3kal2 zti zw[n 8s0r0 8dqnil1bi n7n5 z8szn jcjcrc

Ix1 S7xe

***gb3s2 K7nn7**: W-n k7 zw[n ak9pa kaab[s7 ibi 2k- saa kej8 tzy1s7]tzy1s7

***gb3s2 k3j8**: Ol6wqd87 ni k7 zw[n ak9pa szlzy3 8m= 8sqqj5 n7pa z8szn jcjcrc, zw[n ohun t9 ê fzq zti zw[n zzm8 l9r7xir7s7 jcjcrc n7.

***gb3s4 kcta:** Ol6wad87 szgb3kal2 k9k9 2k- f5n 8j7r0r0 [j- naa zti b7 w-n xe gbzw-n n7yznj5 lqti szp4j5we 8tan z8l4ra zw[n (*r7r7 w[n kqn t9 xzy4w0 zti b7 w-n xe xzy4w0 8wad87 z8szn jcjcrc gan]an. Lqti 7bcrc zy2w0 8wzd77 t7t7 kan 8m=lqra a r2 lara, 8bcrc zy2wo 8wad77 t7t7 kan 8m=lqra a r2 lara, l1m87 zti

lqw6j[, b7 k--wq ti ê s[8tzn rc, ol6wqd87 n szk7y4s7 zw[n k9k9 pztzk8]pztzk8 fun 8j7r0r0 t9 ê b=.

***gb3s2 kcrin**: Zw-n ol6k9pa jqfqfq lqti x4 rqnt7 zw[n 8r7r7 zw[n zk9r0 t7 w-n ti ni 8m5xc lqy3 ko to di zk9k0 8wqd87. W-n n7 k7 w[n n7 zt5nr0 n7pz 8r7s7 i w[n, zw[n ohun ti w-n yan lqzy0 lzti ma axe, zw[n cni t7 w-n ti n7 8bqpzd3 zlqqfiz p2l5, zti b7 8s2wqd87 zr6n jcjcrc se n7 ipq lori w[n si zti ohun t7 w-n t7 yzn lqzy0 n7gbz kan r7.

***gb3s4 karun]un:** Ol6wad87 ni 8j7r0r0 p2l5 zw[n zk9pa l9r7 8dqnim= w[n k9 t9 d7 p3 zti l1yin 8x4wad87 arun jcjcrc zti b7 zw[n ixe w=ny7 ti xe y7padz l1yin zy2w0 8wzd87. Ol6wqd87 t[w[n s-nz lqti j1 k7 w-n o y7padz, w[n 8 t78 s[2ddq]8dqn7m- [w[n n6. W-n kzn n7 lqti ztunb=tqn 4r0 rere nipa z8szn jcjcrc k7 w[n le ba m[r7r8 ohun to xe pztzk8 l1k6n]5n]rcrc. Ol6wqd87 ran zw[n ak9pa l-w- lqti s[l3sccsc zw[n oj5xe zti ipa t7 w-n ti ko tzb7 m5xc boya g1g1 b7i 0b7 zb7 [k[tabi b7i 8yzw9. Zw[n ipa y87 lee p2l5 x7xix3 lqti xzt8ley8n f5n 8d7l3, 8bql0p0 tin5tin5, gb7gbq b-=l6 alqfcs2gbq tzb7 zw[n er3 8dqrayq m7rzn p2l5 [m[d3 kan tzb7 [m[][m[. Z8szn jcjcrc zti 8t-j5 u r2 le4 j[b7 w7p3 8gb3s2 nqz 0 le4 xe3se, o si le s[8dqnim= cni l9r5k[l9r7 zw[n ipa w0nyi, s7b2, zw[n w[ny7 xe 3 szk9so labc b9 ti w6 kori. Zw[n =nz tuntun lqti jc 0b7 tzb7 [k[ab7 8yzw9 xe 3 s2dq/p87ya.)b7 s8 t5n l4 wo b-=l6 alqfes4gbq tzb7 zw[n er3 8dqrayq m7rzn p2l5 [m[nqz tzb7 [m[][m[, so zw[n 8r7r7 r2 gbogbo p2l5 u r2 ki o si mqa s=r= n7pa zw[n 8r4t7 zti =p= zlz rere f5n [m[naa k9 dz b7 0 s7 okun lqti sqr3 ka p2l5 [mp =5n.

***gb3s4 kefz**:)l6wqd87 szlzy3, b12 l9 s8 xztcnum- l9r7 pztzk8 bi 8hz ti cn8k== k[s7 8r7r7 8yzs-t= [w[n lqw6y[zti 8doj5k[nipa y7yan 8h6wzs7. O xe 4k5nr1r1 zlzy3 l9r7 b7 zw[n ak9pa gbogbo ti ni 8faradz lqt2y8nwq zti b7 w-n xe l4 t5n n7 8gbzm-ra b12 l-j- 8wqj5. O ran w[n l[w[b7 w[n xe le n7 zzy0 2r7 [kan lqti mu 8r8nzj0 w[n t2s7wqj5 ju lqti j1 k7 4r0 8lz]k[jq w[n ana 9 gba w[n l[kan t7 9 le m5 w[n 9 rin 8rinzj= 0n7 n7n5 ewu. Ol6wad87 k0 sz8 tcnum- b7 8padzb=s7p0 zg- ara w[n ti se jc dandan to zti b7 y7yzn lqti k[j5 8jz s7 z8szn nqz xe k9 ipa t9 p= t9 lqti

f5n w[n l9kun t7 9 le4 m5 bor7 zw[n 8doj5k[t7 9 r[m- z8szn nqz. El3y87 le 4 wq s7 8m5xc n7pa w7wq zti f7f7 zw[n zxzyzn 8t9j6 t7 9 dqraj6l[s'oju 8xe j6 s7sinmil3 zw[n 8gbzgb[zt2y8nwq.

Rir[zti s7s=r= 8w5r7 s7 zw[n ak9pz lqti xzm5l0 8gboyz zti k7 w-n s8 fzy4 s7l2 f5n 8faram- to ni 8tum= lqtzr7 zw[n 8x1 x7xe w[n, ti o f5n ni znfzzn7 lqti xoj5se to p3ye f5n 8t-j5 ara w[n, zti pzqpzq, k7 w-n s8 gbqrad8 lqti gba 8r7r7 z8szn jcjcrc c w[n b77 9 ti wq, nipa x7xe b12 “Y90 8bzn5j1 c w[n pada si ol5bor7 8x1gun ti o s[8yz w[n axeyori” (Frankl)

M7m5 Xqz $k- Wq S0pin

i. Zw[n ol6k9pa n7 lqti se 8j7r0r0 l9r7 zk0r7 2k- zti b7 9 xe j1m- 8r7r7 w[n.

ii. Mo ran zw[n ak9pz l3t7 lqti ka iwe: “*wqd87 $n8yan f5n *lum=”

iii. Ol6wq d87 b34r4 b7 =r= 8r0ye tzb7 8b33r4 bq wz k7 2k- nqz t9 wq s7 8dqnud5r9

iv. Ol6wqd87 m5 sqz 2k- nqz wq s7 8dqnud5r9 b7 9 xe fi 8dup1 c r4 hzn s7 zw[n ak9pa f5n w7wa a w[n zti lqti j1 kqn m= p3 0un f'oju s-nz lqti r7 w[n n7 sqz 2k- t9 ê b=. (rqn w[n l3t7 [j- zti zk9k0 2k- fun sqz t9 ê b=.

$t0 @k- Sqz Kcta: *tum= F7f0yem= Zt5nxe, *lznz f5n *f0yem= Ztunxe s7 *bqtan s7 D7dqnil2bi lqzr7n Zw[n Alq8szn jcjcrc

$r0çgbz: B7 sqz nqz ti ê pqti l[, zw[n ol6k9pa yc ko lee

(i) Salay3 ohun t7 8f0yem= ztuêxe jc

(ii) Salaye ohun ti or7 =r= nqz jc ni 8bqmu p2l5 zw[n zlq8szn jcjcrc

(iii) M[zti 8l0 zw[n 8lznz fun *f0yem= Ztuêxe s7 4t0 8l4ra w[n

Ix1 S7xe:

***gb3s2 K7nn7**: W-n xafihan 8f0yem= zt5nxe s7 zw[n ol5k9pa

*f0y3m= Zt5nxe j1 8lznz [gb[n o ê ti maa n ran zw[n 4n8yzn l-w- lqti f0pin s7 4r0 buburu tzb7 4r0 8p0r5ur6 gbogbo. Eto 8lznz 8f0yem= aszt5nxe l'afoj5s6n ztiszt5nse s7 zw[n 8s0ro tzb7 8doj5k[d7p0 8dqm= lqsqn. N7gbz ti ohun t9 le tzb7 t7 9 m5 aqp[n dqn7 bq xcl2 s7 wa, b7 a 9 ti xe n7 zk9k0 nqz zti 4r0 t7 9 n szk9so

o wa n7 ko’r7ta y87 xe k9k9, 9 xe pztzj8 ju ip0 t7 a wz l[. Zw[n 4r0 b5bur5 j1 am5nix8sc a s8 mqa y[r7 s7 4r0 8parun.

El3y87 a mqa s7 8gbzgb9 p7n5 8parun w-n s8 le pa 8xes77 wa lqra.

***gb3s2 k3j8**: Ol6wqd87 xe on7r5ur5 zpccrc 8r0n5 z8m-gb-n wq. Zw[n 8r0n5 odi le y7 padz n7pa x7xzt5nxe s7 4r0 o wa gbogbo. F5n zpccrc, l3y8n 8gbz t7 8wqd87 ti f8d7 r2 m5l2 g1g1 bii alq8szn jcjcrc, zw[n 4r0 bqw=n y87 le mqa wq s-kzn on7t=h5n:

“Mo j1 ol9r7bur5k5”

“Lq7 n k0 l4 n7 2m8 g7g6n”

“Lqy3, n 0 n7 dqr7 ji cn7 t9 sok6nfz z8szn y87 s7n5 ay3 4 mi”

D7p9 kq f’ara f5n zw[n 4r0 bqw-n]on]n8, k7 4yzn szt5nxe zw[n 4r0 nqz s7 rere s7 8dqh6n s7 ip0 t7 a wz. N7n7 8gbqrad8 f5n b7 a 9 xe doj5 k[4s8 z8szn jcjcrc zti b7 a 9 xe gb3 bor7 7 r2 n7pa l7l[f5n 8t-j5 atij[.

***gb3s2 kcta**: Ol6wqd87 k- zw[n ak9pa n7 8sepztzk8 8szk9so 4r0 0d8 k9 t9 y7padq s7 8wz 0di.

(k- zw[n ak9pa b7 w-n xe le gb9j5 aqgan s7 4r0 0d8.

Zpccrc: (1) “đ j1 2r7 wz p3 zw[n 8gbzgb9 0d8 w[ny7 j1 09t-?”

(2) “S7sinmil4 zw[n ero y87, ç j1 o mu x zçfzn8 ni tzb7 abur5?

(3) “đj1 zw[n 8gbzgb- w=n]on n8 p4s4 8dqh6n s7 zw[n 8x0r0 naa?”

(4) “đj1 zw[n 8gbzgb9 nqz mqgb-n dqn7?”

(5) “đj1 b7 mo xe ê gb3 p2l5 8gbzgb- w[ny7 xe 8rznw- f5n mi?”

(6) “đj1 4r7 ê bc f5n 8gbzgb- y87?

Bi cn8k==kan bq le dahun zw[n 8b34r4 w=ny7 p2l5 09t-[n5, y90 xe3xe lqti pa 4r0 0d8 gbogbo r1 n7n5 [kzn an w[n.

***gb3s2 kcrin**: K7 zw[n ol6k9pa dqr5k[d72 n7n5 zw[n 4r0 alq8l-gb[n t7 w[n ti n7 n7pa z8szn jcjcrc p2l5 0ye ol6wqd87 nqz, t7 gbogbo w[n s8 gb3 e y2w=.

Zs[kqd87 @k- Sqz

(i) W-n r[zw[n ak9pa lqti xe zr7dqj5 2k-

(ii) Ol6wqd87 xe as[kqd87 2k- b12 l9 gb9s6bq kqre f5n zw[n ol6k9pa fun 8f[w-sow-p=.

$t0 Sqz K2r8n

K9k9 @k-: *lznz *f0yem= Ztunxe N7pa *f=r=yanj5 *lzkojz N7 *bqmu S7 *dql2b8 Z8szn Jcjcrc

$r0çgbz: B7 4to sqz 2k- y87 xe ê par7, ol6k9pa yc ko le e:

(1) P4s4 =nz zbqy[s8 zw[n 4r0 0d8 t9 xe3xe kqn ti n7 nipa z8szn jcjcrc n8pa b12 t7 w[n 9 gb3 8gbeay3 t9 n7 8tum= si

Ix1 S7xe:

***gb3s2 K7nn7**: W-n k7 zw[n ol6k9pa kqzb= s7 gb=ngzn 2k- b12 l[xatuny2w0 2k- sqz t7 9 kojz.

***gb3s2 k3j8**: Zw[n ak9pa gba 2k- b7 w-n xe l4 xe 8dqnim=, doj5k[k7 w-n s8 pa 4r0 t9 ê m5 8r0n5 zbaad8 d8 wq k7 w-n s8 pzzr= [w[n p2l5 4r0 t77 m- kzn f7y1. Zw[n 8r0n5 t7 k0 mu 8rznw- wa n7pa 8gbzgb- zw[n 4r0ker0 gbogbo tzb7 ohun t9 ê m5 8parun bq 8m=.

O dzb7 8wz t7 k0 dara t77 m5 8p0r5ur6 [kzn bq eniyan. N7pa 8gb3s2 0hun aqpan, 9 le m5 k7 zw[n 44yzn n7 0ye ohun t9 ê xe w-n l-kzn t7 y9 m5 w[n ron5 zt5êxe.

***gb3s2 kcta**: Ol6wqd87 szlzy3 8xepztzk8 zti 8lznz 8f-yem= 8szt5nxe s7 zw[n ak9pa. *f0yem= *xzt5nxe j1 ohun 4l0 8t-j5 t7 w-n ti l0 f5n zw[n 4n8yzn lqti j1 k7 w-n 9 fara da or7xir7si 8doj5k[zti 8dzm5 n7 7p0 t7 w-n wz. (ê rzn wq l-w- lqti d1kun 8gbzgb- wa n7n5 8farahzn alq8f[w-y7 n7pa k9k9 4r0 o wa g1g1 b77 8gb3l3w=n 0d9do t7 9 dqra j6l[. (ye k7a dqn zw[n 4r0 t7 9 ê wa s7 [kzn a n wa w0 fun j7j1 b12.

Zw[n 8d-gba nqz r4 3:

A - Am58s2l2 ya

B - *gbzgb-

C - Zw[n zy[r7s7 4r0 o wa gbogbo

D - S7szr7yznjiyzn l9r7 4r0 gbogbo

E - P7pa zw[n 4r0 [kzn wa da p2l5 8pq

Lqti xzt5nxe s7 zw[n 4r0 o wa, a:

(i) O xay2w0 k9k9 4r0 [kzn ati zw[n zy[r7s7 7 r2. Lcyin 4y7, a 9 n7 zr0jinl2 b9yz 4r0 o wa n7 zb6d3.

(ii) O tun 4r0 wa pa, tzb7 kq t5n]un gb3kalc n7gbz t7 9 ti dqj5 p3 9 lqb6d3, tzb7 a ti m[ohun t7 a xax8xe l3 l9r7.

Zw[n Am5yqn]qn]yqn *lznz *f0yem= Axzt5nxe n87:

(i) Lqti t[pin]p7n zti k7k[AB ati C pzqpzq j6l[n7pa k7k[s7l2

(ii) Lqti xzwqr7 zw[n ip0 t9 sqbz f1 mqa ê fa zw[n 4r0 0d8 kan

(iii) R7ron5 n7pa zw[n zx8xe 8r0n5 wa k7 a s8 gb9j5 aqgan si w[n. N7gbz t7 a bq ê tako zw[n ir5f1 4r0 b12, a n7 lqti n7 zw[n 4r0 w=ny7 l-kzn.

(i) X3 zw[n 4r0 mi n7pa ip0 y87 mqyqn l9r7?

(ii) @r7 tzb7 09t- won i mo n7 lqti ti 8w0ye 4 mi l1y8n

(iii) đj1 zw[n 8w0ye m7rzn n bc l9r7 ip0 y87?

(iv) S3 n 0 mqa s0diw=n ara z mi lqti d5r9 tiiri n7 ip0 y87?

(v) K7 lzw[n 8gb3s2 t7 mo n7 lqti gb3 l9r7 ip0 l--l-- y87?

***gb3s2 t9 kzn ni:**

(i) Pil2 zw[n =nz 8r0n5 m7rzn tzb7 zw[n 8gbzgb- t7 9 rzn - l-w- f5n zy[r7s7 zw[n ipa lqti k[j5 8jz s7 zw[n ohun am5x2l2 yq (w7wq 8t-j5). N7pa 8gb8yznj5 n7 lem-lem-, 44yzn 9 mqa m5 zy7padz bq zw[n t87 fa zw[n 8r0n5 0d8 nt7 ko ranni l-w-, xugb-n y90 mu ay= zti 8bzl2 [kzn wq. Bqkannqz a mqa ran ni l[w[lqti sztunxe s7 8r0n5 t7 k0 bqra d[gba t7 9 le4 y[r7 s7 8p0r5ur6 [kzn.

M7m5 2k= wq s9pin:

(i) W-n ru zw[n ak0a l-kzn s9k4 lqti b34r4 8b34r3

(ii) Ol5wqd87 sqlqy3 n7 s9k8 k9k9 2k- sqz b12 l9 rqn w[n l3ti zk9k0 zti ibi 8pzd3 sqz t9 ê b=.

(iii) Zw[n ak9pa gba or7y8n f5n 8f[w-sow-p= zti 8faraj8n in w[n

@k- Sqz Kar6n]5n: S7xe *dqm= zti *szk9xo Ohun T5 Y- $r0 {kzn L1nu L9r7 *dqnil1 Lqzr7n Zw[n Alq8szn Jcjcrc

$**r0çgbz**: B7 2k- sqz y87 xe ê l[so pin, zw[n ol6k9pa y9 le4

(i) Szk9so zw[n ohun t77 y[4r0 [kzn l1nu b9 ti t9 zti b9 ti yc

(ii) Xe 8s7p0dz f5n zw[n 4r0 zy[nil1nu t7 y0 s8 zw[n 4r0 ay[nil1nu t7 y9 s8 fi zw[n 4r0 rere t7 9 n7 8tum= j88r= [w[n

Ix1 S7xe

***gb3s2 K7nn7**: Ol6wqd87 fi tay=tay= k7 zw[n ak9pa kqzb= b12 l9 xzt5ny2w0 4t0 2k- sqz t7 9 k[jq p2l5 u w[n.

***gb3s2 k3j8**: Ol6wqd87 szlzy3 l1k6n]r1r1 ohun t7 *dqm= zti *szk9so Ohun y77 Y[@r0 _kzn L1n6 L9r7 *dqnil1bi Lqzrin Zw[n Alq8szn Jcjcrc Tum- S7.

N7w=n 8gbz t7 9 ti jc p3 zw[n alq8szn jcjcrc j1 4dq t7 mqa ê ron5 xzgb3y2wo, dqj- zti on7b34r4 pcpc 8r0n5 u w[n ni ok6nfz f5n 8dqracnil1bi n7tor7 7p0 t7 w-n wz. *r0n5 0d8 y87 n77 xe p2l5 s7s[4r0 zti iwa w[n di 8d7bzj1, b12 l9 s8 j1 pe 8wz zti 4r0 y87 l9 8gb3ay3 8f0yem= zti 8l4ra w[n r9. D7dqracnil1bi p2l5 4roon5 [kqn, 8m=lqra zti 8xe s7 j1 am5wq tzb7 8y[r7s7 f7fzzye gba 8r0n5 z8m-gb9nwq tzb7 z8f[gb-ny[.

X6gb-n b7 9 ba l4 y7 8r0n5 padz s7 4y7 t7 9 m5 [gb-n dqn7, aj1p3, Alq8szn Jcjcrc y9 le4 xa8 tzb7 m5 8gb3ay3 8dqnil1bi k5r0 n7n5 =r= o rc t7 mqa ê y[r7 s7 8p0ru5r6 [kzn, 0d8]8wz, zti 8bzn5j1 y99 s8, le ron5 zti le4 xe ohun t7 9 m-gb-n zt0ye dqn7 lqti l4 xzm5l0 zw[n 8gb3s2 t7 9 yc s7 8t-j5 8szk9so azr6n jcjcrc.

Igbesc kcta: Ol6wqd87 zti zw[n ol6k9pa f[w-sow-p= lqti dq zw[n 4r0on5 t9 l0 d7 m= (b77 8s0ro êlq zti zs[r3g43) p2l5 8xes7 8gbzgb- zti 4r0 rere t77 xzt5nse s7 44r0. T9 t5m- s7 f7f7 z8szn an w[n sun cn8kan tzb7 nçkankan. W-n ru zw[n ak9pz l9kzn s9k4 lqti gba oj5xe e w[n b77 ix1k7 w-n gba 09t- b9 t7 w6 k9 r7 n7 ip0 y9w6 tqn le wz, k7 w-n s8 yanj5 8s0r0 t9 bq wz êl2.

Zpccrc: D7p0 k7 w-n o mqa gbinnuk5n l9r7 zw[n 4r0 b77: "N 0 lee san k5r0 n7n5 z8szn y87 zyzfi b7 8yql3 tzb7 8yzw9 o m=-mi bz ku", "O xe3xe f5n 44yzn lqti n7 ir5f1 4r0 b77: "Ohun gbogbo t7 mo bq le xe ni mzq xe t7 n 9 fi koj5 8jz s7 z8szn jcjcrc y87 n7pa 8xzm5l0 zti 8gb[ran s7 zw[n 8t-ni zti 8t-j5 l-nz 8x4g6n". W-n ran zw[n ol6k9 l[w[lqti gb9j5, aqgan s7 zw[n 4r0 z8m-]gb-nwq gbogbo n7pa s7szm5lo zw[n 4r0 ol6k9pa l[w[lqti gb9j5, aqgan s7 zw[n 4r0 z8m-]gb-nwq gbogbo n7pa s7szm5lo zw[n 4r0 amqraj7p3p3 t7 y9 m5 =p= 8r4t7 wq f5n [j- =lz.

***gb3s2 kcrin**: W-n r[zw[n ol6k9pa nqz l-w- lqti szm5l0 8gboyz]aracni zti 8rznw-]aracni lqti d7p0 4r0 ztij- t7 k0 n7 8dql1bi b9 ti w6 9 m[.

M7m5 2k= wq s9pin:

(i) W[n y8n zw[n akopa f5n ifetisilc zti 8farabal2 c w[n

(ii) W-n r= w-n lqti szwqr7 t7 9 dqj5 s77 l9r7 2k- t9 s2x2 par7

(iii) (m5 2k- sqz wq s9pin n7pa b7 9 ti xe zlzy3 2k- n7x9k7.

Sqz @k- Kcfa

K9k9 @k-: F7f7 {gb[[gb-n)un *f0yem= M5 $r0 *parun zti *dqnil1bi kuro Lqzrin Zw[n Alq8szn Jcjcrc

$r0çgba: B7 4t0 2k- sqz y87 xe ê l[s9pin, zw[n ol6k9pa yc k9 le4

(i) Xe 8dqnim= ohun t9 jc 8y[nu s7 8m=

(ii) Pa zw[n 4r0 tzb7 8r0n5 z8m-gb-n wq run

Ix1 S7se:

***gb3s2 k7nn7**: W-n k7 zw[n ol6k9pa kqzb= p2l5 zy3s7. B12 ni ol6s4wqd87 xzgb3y2w0 s7 2k- sqz t7 9 k[jq.

***gb3s2 kej8**: Ol6wqd87 xzp4j5we ipa d7dqnil1bi b77 8x0ro 8p0r5ur6 t77 m5 k34yzn r7ra r2 bii 8x0ro 8p0r5ur6 [kzn t77 m5 k34yzn r7ra r2 b77 alq8p3, alq8lqgbqra zti cni ewu, n7pa b12 t7 ê fi z8lera r2 sun zw[n 4r0 to x5yo lqtzr7 =nz 8r0n5 u r2. Zw[n 8r0n5 zbaad8 y87 n' d7 alq8szn nqz l-w- lqti xzwqri zti k7 9 gb3 8gb3s2 8t-j5 ara r2 p2l5 8rznw- =nz 8gbzl9d3. On7t=h5n ê 8jqkul2 k7qk7q b12 l[gbzq m-ra n7pa zw[n 4r0 t9 ti 8b8kan wa. +p= 8gbz ni ip0 z8dunn5 ê wqye lqtzr7 8r0n5 zt8gbz degbz zti 8y[nu 8m=.

***gb3s2 kcta**: Ol6wqd87 fun "*y=m=l1nu" l9r7k8. 0l6y[]4r00m=l1nu ni zw[n 4r0 t7 zw[n 44yzn mqa ê ni n7n5 [gb-n [n w[n t7 9 mqa ê m5 w[n par7 ero w-n s7 zbq buburu. Inu [kan gangan ni ir5f1 zw[n 4r0 b12 mqa n'gb3. Ol6wqd87 szlzy3 pe ohun m1ta l9 mqa ê fa 8p0r5ur6 [kzn w-n ê p4 3 n7 "*m= Mcta" Nkzn y87 n fi ipq m5 on7kqluk5 lqti r7 ara w[n b77 cni 0d8 l2dq 0d8 r7 agb4gb4 w[n lo'di, w[n 9 s r7 0d8 n7pa =la a w[n bqkan nqz. Y90 t5n szlzy3 s8wqj5 s77 p3 9 t7 wz n7n5 8gb3kalc p3 zw[n 4r0 t9 lqb6k6 y87 mqa ê r8n pap= ni. Im[b5bur5 m1ta y87 ni zw[n 4r0 0d8 alq8f[w-yi t77 gb3 lqy8kq 0ye 4n8yzn:

(i) Zw[n alqra

(ii) Zw[n t9 k6

(iii) {j- =la

F7f7 Oj5)d8 Wo Ara Cni

On7xoro y87 y90 r7 ara r2 b77 alq8lera, alq8p3 zti alq8yc. Y90 f7 zw[n 8r7r7 b5bur5 u rc gbogbo sun zs8xe agbqra, [gb-n tzb7 iwa. Ir5f1 2dq b12 k0n7 zw[n 4r0 8dqnil9ju s7 oj5xe t9 n7 8tum=, y- n7 8gbzgb[pe 0un le4 xe 3 tzb7 ir5f1 ix3 b12 k0 t- s7 0un. N7 8t2s7wqj5 s77, y9 r7 ara r2 g1g1 b77 alq8yc zti alq8jqm= nkankan n7tor7 4r6 b5bur5 t9 t7 n7 t1l1 zti p3 9 r7 ara r2 b77 cni 2k=. A mqq r7 8lzk[jq b77 0k44s0ro t7 k0 le4 d7 p2t1l2; z8le4 doj5k[8x0ro t5m= s7 8jqkul2 pqtqpqtq. (r7 ara r2 b77 alq8k5nj5w=n n7pa =la a r2 m[lc. Ip0 y87 y9o mu lqti p4s4 ara r2 f5n 8kqr7s[zti zw[n 8bzn5j1.

***szgb3kal2 Zw[n *r7r7 N7 +nz T7 9 L0d7**

W[n j1 zw[n 4r0 alq8se d33 d3 p2l5 8sed33d3 n7 =nz t7 9 l0d8 t7 mqa ê m5 k34yzn r7 ay3 b7 ohun t9 bur5 ju b9 ti wz l[. On7t=h5n y99 mqa xe zt5pal2 zj[xep= or2 p2l5 zy7kq a r2 b7 zt5pal2 zj[xep= [r2 p2l5 zy7kq a r2 b7 zzm8 8jqkul2, z8n7 0un z8lqgbqra. Oj5l9w9 8m= nqz xzfihzn on7r5ur5 8yapa k5r0 lqra 8r0n5 t7 9 jinl2, ztip2l5 w7wo ohungbogbo bqkanqz, 8r0n5 zr7yznjiyzn y7yzn lq8n7d87, s7sodigb7gb00r0 abbl. On7t=h5n y90 m=-m= lq8f[w- y7 s4tum= ip0, b9 ti 2 j1 p3 ohun t7 9 dqj5 tzb7 zlzy3 to xe3xe le suy[. Y9 xzm5l0 r2 lqti yc f5n ero 8par7 0d8 i r2.

W7wo Oj-[wqj5 L-nz)d8

Cni 2r6 nqz n’r2t7 p3 8x=ro 0un l-w-l-w- tzb7 8doj5k[0un y90 l[t3t7 z8l9pin. B7 ir5f1 2dq b12 ti ê wo =la, y9 mqa ri 8gb3ay3 8s0ro z8l9pin, 8doj5k[, z8n7, a8dqnil9j5, z8s7rznw-, ati z8se3xe. Zw[n 4r0 b77: “k0 xe pztzk8” “K7nni 8w5l0 o rc?” “K0s7 ohun t7 mo xe t9 m5 8yzt= wq” “K0 s7 cni t9 f1 m[r7r7 ipa z mi” “Nçkan ti bzj1 k[jq zy4”.

***gb3s2 kcrin**: Ol6wzd87 xe 8dqm= b12 l9 szlzy3 y3k3y3k3 zw[n zpccrc ohun t9 j1 ewu si 8m=, ti w-n tun ê p4 ni: zw[n 4r0 0d8 alq8f[w-y7.

Gbogbo tzb7)fo $r0: R7r7 ohun kan bz8]bz8 k9 wz. Fun zpccrc riri aracni b77 on7jqkulc pqtqpqtq. Cni t7 k0 le xe oj5se t7 w-n bq f5n]un b9 ti yc t7 9 s7 ê r7 ara r2 b77 alq8jqm- çkankan.

***m5wqs9pin Lq8n7d87**: $y7 t5m= si m7m5 4r0 wq s7dzn5d5r9 lq8 szgb3y2w0 ohun t7 9 yc. F5n zpccrc, ok6nrin ti k0 s[n7pa 8yzw9 wa b7n5 9 s8 m1nu =r= j9nq p3 k0 n7 in5d7d6n s7 [j- =la 0un. (fi zw[n zlzy3 t7 9 k6 s7l2.

***r0m7 *dzr5dzp-**: Ohun kan gb09g8 n8pa n7pa zb6dq ewu y87 ni 8tcnum- l9r7 b9yq tzb7 zzy0: N7 8gbz t7 on7t=h5n bq wo gbogbo çkan l9k4r4 r3r3, el3y87 a s8 m5 z8d-gba tzb7 w7w0 bz8bz8 wa, zti n7tor7p3 y9 pzdqn6 ohun 4l0 pztzk8. Iha t7 9 k- s7 8x2l2 y90 mqa l[lqti igun kan s7 4kej8. [kan lara ewu ironu 8dzr5dzp= ni agbara t7 9 n7 l9r7 b7 oêt=5n y90 ti xe mqa x4dqj- ara r2. T7 cni t7 a ê s=r= o r2 y87 k0 bq jq fqfq, 9 gbud= j1 cni 8jqkul2 tzb7 ap=dz. K0 s7 zy4 f5n zx8xe tqb7 0p4.

X7xzxzyzn Ohun Z8r7: $y7 ê wqy3 n7gbz t7 on7t-h5n bq yan alaye 0 d8 t7 0 s8 ê ron5 l3e jinl2jinl2 deb7 pe zfoj5sun un r2 pqdz x90k5n, b77 8kqnomi kan t7 9 s[keke omi kan di d5d5. (t5m= s7 w7wo ohun kan t7 k0 ohun kan t9 s8 j1 p3 0un l9 ba gbogbo 4y7t9k6 j1. On7kqluk5 l9 ni as1 c r2. Zw[n kan n7 zp0j6 8kobiaras7 s7 zbqkqbzq z8t= 8dqj- tzb7 s7se s7 w[n n7 =na z8yc. Zw[n t9 k6 n7 zb6d3 lqti szgbqk0 ewu b7 9 ti w6 k9 k3r3 t9 (b9yq s7ra a w[n tzb7 s7 ol9l6f1 c w[n) b12 nqz ni w-n mqa ê b2r6, dzzm5 zti 8payz [kzn. N7pa 8lznz s7s3, 4n8yzn le3 m5 k7 8lzk[jq 9 f2 s77 k7 9 s8 n7 4r0 k7kor0. N7gbz t7 zw[n çkan ti k0 dqra bq jqde n7n5 4r0, t7 9 yzt= s7 zw[n 8r7r7 rere t7 9 y77 ka, n7gbz nqz ni zw[n ilzk[jq =5n y90 bur5 ju b7 w[n t7 wa l=.)pin gbogbo r2 ni p4 gbogbo 2r6 on7t=h5n, zdqn6 zti 8r7ra gbogbo y9 di p5p= s7 7 n7tor7 w-n ti gba 4r0 [kzn pqtq lq8 y[ohunk9hun s7l2. N7 pztzk8 j6l[, b7 oêt=5n bq x1, yo s[zt-nz 44r0 r2 n6 n7gbz nqz ni 8r0n5 y9 di 8p9r5ur6.

X7szfik5nfub9tiycl[: El3y87 nii xe p2l5 n7n7 4r0 w7p3 8x2l2 0d8 kan l9 sok6nfz =p=l[p= zw[n 8s2l2 0d8 alq8l9pin. (j1 m7m5 8s2l2 ni zpzçlqka p3 b12 nqz l9 se r7 lq8 se zgb3y2w9 zw[n ohun t7 9 y77 kq. (j1 4r0jz 8parun t7 9 le pa 8dqj- cni

lqra n7pa z8s7 2r7 t7 9 jinl2 tzb7 t7 9 n7 8p8l2 l9r7 çkan tzb7 8x2l2. On7sqbzb7 8parun y87 k0 n7 szgb3y2w= zw[n 2r7 t7 9 y7 8x2l2 kq tzb7 ip0 ka.

S7s[as[regee l-p= 8gbz j1 8s[[r[lqsqn, b78 cni p3 zw[n 0fin kan j1 k7k[p2l5 0k5ta t7 mqa ê s0diw=n 8d6nn5 cni. Zpccrc 8w=r0jub9ti ycl- ni: "Gbogbo 44yzn mqa ê wo à7 b78 alq8p3…k0 s7 ohun t7 mo xe t9 t-… k9 s7 cni t7 9 n7 0ye 4 mi… N k0 le gba cnik1ni gb- wu y8… $t0 ilera z m7 0 l4 dqa ju bqy87 l[b9 ti w6 k7 n gb8yznj5 t9".)pin ero rc dq l3 l9r7 2r7 kan p3r3 lq8 szgb3y2wo zw[n ohun m7rzn t7 9 xe pztzk8 .

Zw[n [r[t7 8r5 4n7yzn y87 mqa ê l0 ni "gbogbo, cn8k==kzn, k9s7, lqy3, n7gbz gbogbo, gbogbo 4n8yzn, zti k0s1n8kan". Ohun kan t7 w7wo ohun gbogbo bqkan nqz n7 ni 8d9j5s[gbogbo zgbqy3 lq8 xzm5l0 09t- p3 8ran 4n8yzn lqgbqra 9 s8 le, 8se e wa s8 dql3 l9r7 or7xir7xi.

Ajcmqdzqni: El3y87 n wqy3 n7gbz t7 4n8yzn bq r7 ara rc b77 ok6nfz s7 8gb3ay3 0d8 t7 9 bq ara r4 b12 s7 ni k0 m[nkankan n7pa rc. (ê xcl2 lzy7kq r2 b77 w7p3 ohun n8kan l9 ê scl2 s7. Okuçrin kan l9 maa ê l3r0 p3 iye 8gbz t7 8yzw9 o r2 ba' l9 rc 0un, a mqa ri i p3 9 n7 0un ti s5 u. +nz m7rzn gb09g8 t7 zj2mqdzqni n7 ni w7wo ara r2 lqra zw[n 44yzn gbogbo. "W-n l9w9 j6 l[… 9 lqxe y[ri p2l5 ob8nrin j6 m7 l[… Mo l1t=- s7 2b6n ju gbogbo zw[n t7 w-n ê fun l[… W-n l4 lo 2r= ayqra b7 zxq j6m7 l[… Mi 0 szseyor8 b77 ti w[n…

W-n t87 l1y8n ju 4m7 l[. Ip0 8lera z mi ê bur5 s77 ju t'zw[n 44yzn t7 9 k6. Zzy4 fun zfiw3 k0 le8 tqn lq7. 4r0 t7 9 farasin ni p3 8xerere cn8kan jc m- =p= 8b34r4. On7kqluk5 y9 mqa szfiw3 ara r2 p2l5 u cl=m78. B7 tcn8kan bq dqra j6, 8d6nn5 u r2 f5n 8gbz d72 ni. B7 t8 c bq bur5 j6, in5 u rc y9 bzj1 lqw[n =nz kan. Ol9r7 8r0n5 alqabi t7 [l-kzn zf4mi mqa ê ni ni: x7se 8tum= 8r7r7 gbogbo, gbogbo zj[s[, gbo 8w0s7 s7 ip0 0 rc. N7 kcy8n o 9 r7 ara z rc b77 on7r0b8n5j1 j6l[, tzb7 b7n5 ju b9 ti yc l[.

***xel-p=** (*jzàbq) tzb7 Zd7nk6 X7szxer3g43 tzb7 zs[r3g43 pztzk8 çkan (b77 zsey[r7 cn8kan) tzb7 m7m5 zd7nk6 bq çkan n7 =nz z8t- (zw9m-ni cn8kan t7 9 dqra j6l[tzb7 z8p3 cn8kan). W-n t5n ê p4 3 n7 8tznjc oj5. $y7 n7 7 xe p2l5

8h4r8m= çkan ju b9 ti yc l[. W-n mqa ê ret7 4s8 ztunb=tqn t7 9 l3wu j6l[. Zw[n 4r0 jzàbq ê b2r2 p2l5 zw[n =r= b77 “kq n7” “kq n7 2r= ayqra b7 zxq y87 dqk1 ix3”…” “Kqn7” “kq ni 2r[ayqrab7 zxq y87 xo x1 l2” “kq ni zw[n 44yuzn fi n7 r1r8n]7n” “kq n7 8jqnu [k= oj5 irin nqz s[x3 l2” “kq n7 [k[0f5ruf5 y87 gbinq” “kq n7 [k[= mi fim7 s7l2 l[bq el0m7rzn”.

B7 8jzàbq bq zti p3 9 xcl2, w-n ê xcl2 l12k--kan. Zw[n ti ê ru enu 8jzàbq ê l[kqzkiri b77 cnip3 ewu =5n ti xcl2 tzb7 9 f1 scl2. W-n mqa ê wz b77 “xck2xck2”. Zd7nk6 n7 0d8kej8 *xel-p=. (j2 8foj5]k33r3 ohun t7 9 wuy8. Ob8nrin le 4 mqa foj5 k3r3 ara r2 n7t9r7 ko m5ra dqa to. (gbzgb3 zp-nl3 t7 9 n7 lqtzr7 p3 9 j1 alqgbzxe t7 9 jqfqfq, 8yq rere, aya t7 9 m[8t=j5 [k[. Ol-yzyz alqbqgb3 zti =r2 t9 j1 ol90]9t- ()d8or5k[)

F7f5nl9r5k[zti Zx8f5nl9r5k[:)pin w7w0jub9tiycl[ni 4y7. D7p0 x7xzp4j5we zx8xe cni, cni 0r=-kzn xzm8 0d7 sqra 0un alqra: “Alqzdqn6 ni mi” “Mi 0 se dqadqa r7” “Mo m= p3 on7jqkul2 ni m7” “Mo l4 mq par7 4t0 0 m7”. N7gbz t7 8wz cn8kan szb6d3 s7 =nz cn8kan, on7t=5n y90 ri g1g1 b77 cni 0d8.

)d8or5k[n77 xe p2l5 x7xzp4j5we 8x2l2 p2l5u 4d4 t7 9 k5n f5n 2d6n[kzn.

Oh6n S’9yc: $r0 8parun y87 b77 xe p2l5 8gb8yznj5 lqti ru ara cni s9k4 p2l5u “yc ati k0 ye” b77 k7 w-n nzz yzn zti. K7 w-n bq ni w7 k9 t9 di p3 on7t=5n gb3 8gb3s2. “J1 dandan” zti “O yc” j1 0 daraç. Ztunb=tqn zx8xe okzn ni 8dql1bi. B7 cn8kan ba s[gb9l9h6n “9 yc” s7 zw[n kan, 8b7n5, 8nira zti 8run5 êlq ni y9 gba okzn an w[n. Cni z8p3 y87 ê lo ipz zti 0fin t7 k0 xe3 t2’ n7pa b7 0hun zti zw[n t9k6 xe ê xe. Gbogbo zgb3kal2 0fin r2 l9 bur5. Y9 b2r2 s77 dqni l1bi n7pa 8dqj- [r2. *se zti 8h6wzs7 zw[n t7 9 yzt= s7 tiw[n yoo mqa b7 w[n n7n5. *se e w[n zti 8h6wzs7 w[n k0 pap=. (yc k7 w-n m[zw[n 0fin nqz k7 w-n si faram- w[n. +p=l-p= lo n fara ni zw[n kan p2l5 zgb3kal2 w[n, bcc ni w-n ê fi 4y7 to l3 ju b12 xe ara w[n. N7pa 4y7, w-n q s[ip0 8yznu w-n did5p=. *r4t7 wa k0 yc k0 ja’sqn. Zpccrc

K7ka $r0 {kzn: Lq8n7d87 ni cnikan y9 par7 4r0 [kzn an r4 zw[n kan n h6wz 0d8 s8 0un. F5n zpccrc: “Mo le s[pe ko xe ni t7 9 f1rzn mi n7t9r7 b7 w-n xe ê xe”. K7ka 4r0 [kzn n77 xe p2l5 ohun t7 a p4 n7 8w0s6n”

K’cn8kan r0 w7p3 zw[n 44yzn n l3r9 b7 0un ti l3r0, b12 nqz ê xe. Ir5f1 4yzn b12 l3r0 p3 b7 zw[n bq ê b7n5 s1n8kan, zw[n t9 k6 nqz n7lqti b7n5 s77 p2l5. B7 o ba n7 4r0jz 8k=-l4 lqra ju b9tiy1 l[, o ê ret7 k’zw[n to’y7[ka nqz se b12. B7 o bq gb3 8daj- kan kal2 l9r7 nkznkan, o ret7 k’zw[n t9’y7[ka nqz 9 xe b12 k7 w-n s8 gba 4r0 0 re. Zw[n t7 ê szszr0 l9r7 0kzn cl0m78 mqa wa ‘si 0pin 8x2l2 l9r7 ohun t7 9 bq 4r0 okzn w[n mu. T7 4r0 w[n ba jqs7 zx8xe, w-n a mqa s8wzh6. N7 4d4 m7rzn, 4r0 o w[n ko wqy3 n7tor7 8f8d7m5l2, x6gb-n n7pa zs8r0 4r0 [kzn s7 zw[n 44yzn t9 k6. K0 s7 zy2w0 f5n zw[n 4r0 =kan w=n ycn. W-n wq y3 lqtzr77: [gb-n in5, 8fif5nni aszn, tzb7 lqti =kan tzb7 ekej8 8r7r7, x6gb-n k87 xe ohun t9 xe3 gbzgb-.

Zx7xe Aw0rzw=: N7n7 8ret7 p3 abur5 9 xcl2 zti p3 9 gba 8m=lqra p3 abur5 y9 xcl2, b12 l9 n7 8dqnil9j5 p3 zs[-l4 nqz j1 ohun t7 a ti k[.

)diw=n Ara Cni: $4yzn a mqa n7 8pinnu alq8n7d87, lqti fzy4 s7l2 f5nra cni b7 cni zy3s7. B11ni, lqti wo ara cni n7 zw0yc. $yzn n7 lqti xe b12 l-p= 8gbz tzb7 l21k==kan.

***foj5k3r3 Ara Cni**: El3y87 d5r9 f5n 4r0 t7 k0 n7 8gboyz ara cni n7n5. (n77 xe p2l5 r7r7 ara cni n7 =nz 0d8. On7t[h5n le r7 ara r2 bii z8p3, alq8ye k7 9 s8 fi zw-n 8r7r7 alq8bqra d-gba r2 sun a8lqgbqra, 4r0 tzb7 zb6k6 8wz tab7 z8lqgbqra t9 lqti xe zw[n ohun kan b7 9 ti yc. On7t=5n ê r7 ara rc b78 cniz8f2 zti alq8jqm-çkankan. (r7 8x0ro b77 ohun t7 k0 le4 gbzt5nxe bcc l9r7 ewu n7n5 d7d5r9 t6ri s7 8doj5k[nqz. Zpccrc “N 0 le xe 3”. “N k0 l1wz b7 zw[n t9 k6”. “K0 x3ni t9 le f1rzn mi” “N 9 j2 cni 8jqkul2 laye” “N k0 yc lqti wz lqy3”. “Ol9ribur5k5 ni m7”.

***r0n5 $r0 {kzn**: *r4t7 p3 4r0 0d8 [kzn kan ê xzpcrc b7 zw[n çkan ti r7. F5n zpccrc: “Mo n7 8m=lqra r2, n7tor7 nqz 9 gbud= j1 b12” “Mor09 b12, b9 xe yc k9 r7 n8 ycn.”

***gb3s2 karun]un**: Ol6wqd87 t- zw[n ak9pa s-nz s7 b7 w[n 9 ti mqa 8dzr5 zti 4k4 4r0 k5ro.

M7m5 @k- Wq S9pin: Zw[n ak9pa n7 lqti xzw0f7n ir5f1 4r0 zti 8m=lqra gbogbo t7 z8szn jcjcrc ti gb3jqde lqra w[n f5n 8j7r0r0.

(ii) W-n k8 zw[n ak9pa f5n 8farabal2 c w[n

(iii) W[n r= w-n lqti wq k5n 8m= l9r7 4t0 2k- t9 x2x2 pqr7.

(iv) Ol6wqd87 d87 szlzy3 n7x9k7 l9r7 2k- [sqz nqz

@k- Sqz Keje

K9k9 @k-: L7lo *f0yem= Zt5nxe lqti T5n Ipa $r0 Xe

$r0çgbz: B7 2k- y87 xe ê par7 l[, zw[n akopa y9 le4:

(i) Szlzy3 b7 8f0yem0 zt5nse ti ê xix3

(ii) Lo 8f0yem= ztunxe lqti m5 zy7pzdz bq ipa 4r0

Ix1 X7xe:

***gb3s2 k7nn7**: W-n k7 zw[n ak9pa kqzb= s7 ibi sqz 2k- tuntun, b12 lo xzt5ny2w0 2k- [sqz t7 9 k-jq.

***gb3s2 k3j8**: Ol5wqd87 szlzy3 s78 l9r7 ohun t7 8foyem= ztunxe j1 zti b7 9 ti ê xix1. *f0yem= ztunxe j1 ohun it-j5 t77 ran zw[n 4yzn l-w- lqti gb3 8gb3ay3 t9 n7 8tum= zti ipq. (ê j1 kqw[n 44yzn m= pe k87 xe ip0 t7 w-n wz l9 ê m5 wzhqlz wq 4r0, a8l4ra zti 4r0]8jqkul2 sugb[n 4r0 zti 8gbzgb- [w[n l9 ê fzq. N7n7 4r0 rere y90 m5 zd7nk6 bq wzhqlz p2l5 zw[n t9 k6 t7 9 s8 rqn 8lera r2 l-w-. Ol6wqd87 ran zw[n ak9pa l-w- lati xe 8dqm=, s4gb3l3w-n, k[j5]8jz, k7 w-n s8 xe l9d7 s7 z8n7pinnu zti 8jqkul2 aracni t7 y9 ran on7bzqrz l-w- lqti t4t2 b=s7p0. $y7 wqy3 lqtzr7 l7lo 00g6n zti s7szm5l0 8t9j5 t7 9 p3ye.

***gb3s2 kcta**: Ol6wqd87 szlzy3 ztip3 9 xzw0f7n zjoxep= t7 9 wz lqzqr7n, 4r0, 8m=lqra zti ixe p2l5 zw[n ak9pa.

Ol6wqd87 szlzy3 l1k6n]5n]r1r1 s7 zw[n ak9pa ipa 4r0 o w[n xe n77 xe p2l5 2d6n [kzn zti 7h6wzs7. (t5n szfihzn pztzk8 8rznw9 8gbzgb-. W-n t5n k- w[n b7 z t77 fi 8f0yem= zt5nxe t5n 8r0n5]cni xe l9r7 ok6nfz ip0 t7 w-n wz l-w-.

El3y87 wq p2l5 8r4t8 p3 y9 m6 4r0 tuntun zti 8szk9s9 tuntun f5n 8gb3ay3 e w[n p2l5 8t-j5 t7 9 p3ye.

***gb3sc kcrin**: W-n f5n zw[n ak9pa lqçfzn7 lqti s'zridqj5 l9r7 k9m9 2k- nqz.

M7m'1k=- Wa's9pin:

(i) W[n ki zw[n ol6k9pa k5u x3 takuntakun f5n 8farabal2 c w[n

(ii) Ol6wqd87 xe zt5ny2w-0 2k- l3r3f43:

(iii) W-n rqn zw[n ol6k9pa l3t7 8gbz zti ibi gb=ngan 2k- f5n sqz to' ê b=.

***pele @k-[Sqz K1j[**

K9k9 @k-: Zk9p= *szk9so $s8]*wad87 ati *f0pins7 *t-j5]Ara

$r0çgbz: B7 4t0 2k- sqz y87 ti ê par7 l[, zw[n ak9pa y9 le 4:

(i) Salaye zw[n açfzn7 t7 w-n t7 n7 lqtzr7 4t0 8dqs7 nqz, zti b7 w-n ti xetqn s7 lqti mqd8n]iêk6 bq 8jcy[*dqnil1bi l-j- o wqj5

(ii) Par7 zw[n ohun 4l0 $s8]*wqd87

Ix1 X7xe

***gb3s2 k7nn7**: Ol6wqd87 ki gbogbo ak9pa kqzb= s7 ibi 4t0 8dqs7 t9 k1y8n. (y8n w-n f5n 8f[w-sow-p=, w7wq d33d3, ati l7t4t4d3 n7 gbogbo zk9k0 4t0 nqz.

***gb3s2 keji**: W-n r[zw[n ak9pa lqti szlzy3 ohun tqn ti j4r4 lqt2y8nwq lqtzr7 4t0 8t-j5 nqz, zti b7 w-n ti xetqn s7 lqti szt5nxe s7 8fqarahzn 8dqnil1bi [j-[wqj5 zti zw[n 8x0r0 ip0r5ur6 t7 9 r= m- [n.

***gb3s2 kcta**: W-n r[zw[n ak9pa lqti b34r3 8b34r4 l9r7 4t0 2k- sqz k==kan.

***gb3s2 kcrin**: W[n s[fun zw[n ak9pa pztzk8 8xzm5l0 8m= ti w-n ti n7 lqk09k0 4t0 2k- nqz lqti k9j5 zw[n 8x0ro t77 y[2r0on5 l1nu. K7 w[n s8 fi zw[n ck[0hun 8lznz t7 w-n t7 k- soj5 8xe n7 k7k5n.

***gb3s2 kqr6n]5n**: Zw[n t77 xe am5gbql3gb2 1 ol6wqd87 xe ixzk9so zti p3, w-n xz xep3 l9s77 zw[n ohun 4l0 8s4]wqd87.

M7m'1k=- Wqs9pin:

(i) W-n ru zw[n ak9pa l-kzn s9k4 lqti s[4r0 8kcy8n tzb7 =r=8w0yc t7 w-n bq n7

(ii) W-n r= w-n t9'b12 g1 lqti szm5l0 n7 k7k5n zw[n 2k- zt[gb-n t7 w-n ti n7 lqk09k0 4t0 2k- nqz.

(iii) Ol6wqd87 pari 4t0 2k- sqz naa b7 9 t7 dupc l-p=l[p= l[w[zw[n ak9pa f5n k7k9 ipa pztzk8 n7n5 4t0 8t-j5 naa. Bcc l9 m[r7r8 zp-nl3 zti zçfzn7 lqti j1 alqbzp7n n7n5 8tzn ay3 e w-n.

(iv) Ol6wqd87 m5 4t0 8t-j5 ara ti sqz nqz wq sopin

IGUN *SZK(SO

Sqz k7nn7: *fqzrz zti Z8s3wqd87 *szk9so

$r0çgbz: B7 4t0 2k- sqz nqz t7 ê par7 l[, ol6wqd87 yc k9 le 4:

(i) Szgb3kal2 8lznz 8t-j5 t9 l-[r8n p2l5 zw[n ol6k9pa.

(ii) F5n zw[n ak9pa n7 8dqnil1k=- n7pa gb6ngb6n zti 8lznz 2k- naa.

(iii) Szk9so zw[n ohun 4l0 f5n 8s4wqd87 lqti szk9j[p= 4sii w[n.

Ix1 S7xe:

***gb3s2 k7nn7**: Ol6wqd87 k7 zw[n ak9pa kqzb= s7 ibi 4t0 nqz. (d-r2 1 p2l5 zw[n ak9pa.

***gb3s2 kej8**: Ol6wqd87 fzy4 s7l2 f5n 8m[rancni lqzrin zw[n ak9pa zti ol6wqd87 n7pa x7xzfihzn ara w[n. W-n fi dq zw[n ak9pa l9j5 p3 zx7r78 w[n k0 le hzn s1n8k==kan.

***gb3s2 kcta**: Ol6wad87 p4s4 zpap= 4t0 nqz. O xzlzy3 8d7 pztzk8 f5n 4t0 nqz, b12 l9 b2b2 f5n 8f[w-sow-p= [w[n.

***gb3s2 kcrin**: Igun m3j44j8 szd3h6n l9r7 zk9k0 zti 8gbz t7 zw[n zk9k0 8pzd3 e w[n y9 j2 1. W-n si j7j[m[zw[n zk9k0 zgb3kal2 ofin t7 9 r[m- 4t0 8wad87 nqz. Zw[n oj5xe ti ol6wqd87 n ret7 lqt=d= [zw[n ak9pa ni w-n xe lqlzy3.

***gb3s2 karun]un**: Zw[n ohun 4l0 8s4wad87 (*gb3l3w=n f5n *dqnil1bi, *gb3l3w=n Zt8lcy8n Zgb4gb4, Ati &gb3l3w=n *lera Oj5xe Ara Cni) ni w-n szlzy3 f5n zw[n ol6k9pa p2l5 it[s[na lqt-w-[ol6wqd87 zt'zw[n Am5gbql1gb21.

M7m1k=- Wq S9pin:

(i) Ol6wqd87 d5p3 l-w- zw[n ak9pa f5n 8f[w-sow- p= o w[n zti ak9k0.

(ii) Ol6wqd87 r[w-n lqti wq s7 i bi 4t0 2k- t9 ê b-, b12 l9 rqn w[n l3t7 [j-, 8gbz zti gb=ngzn 8pzd3.

Sqz kej8

K9k9 @k-: Ohun J7jc Zti Er3 *dqrayq

$r0çgbz: B7 4t0 2k- sqz nqz ti ê par7 zw[n ak9pa yc k9 le 4

(i) Szlzy3 *gb3ay3 *lera

(ii) Dqr5k[zw[n nçkan t7 9 yc n7 x7xe lqti gb3 n7 8lera.

Ix1 X7xe

***gb3s2 k7nn7**: Ol6wqd87 n7 k7 zw[n ak9pa szlzy3 b7 8gbeay3 8lera ti y3 w[n s7

***gb3s2 kej8**: Oluwzd87 m[l3 ohun t7 zw[n ak9pa s[. (j1 k7 w-n m= w7p3 8gb3ay3 8lera ni =nz t7 9 mqa ê ran zw[n 44yzn l-w- lqti xe zw[n çkankan lqti j2 gbqd6n 8gb3ay3 8lera, l3m87 g7g6n p2l5 zlqf7z.

***gb3s2 kcta**: Ol6wqd87 szlzy3 zw[n ohun t7 w-n n7 lqti m= lqti gb4 lqlzfqf7z. Zpccrc; j7jc o5njc asaral99re, x7xe er3 8dqrayq, x7xe 8t-j5 ara zti zy7kq zti n7n7 8sinm7 t7 9 p3y3.

***gb3s2 kcrin**: Ol6wqd87 r[zw[n ak9pa lqti xzfik5n 8gb3aye 8lera k5n ay3 3 w[n.

***gb3s2 kar6n]5n**: Zw[n ol6k9pa n7 zçfzn7 lqti b34r3 f5n 8y4nznq l9r7 ibi t7 9 ba yc.

M7m5 @k- Wa'S9pin

(i) Zw[n ak9pa gbe 0s6bz k'are f5n zk9k0 zti 8farabal2 w[n

(ii) Ol6wqd87 r= w[n lqti p3j5]p3s2 s7 ibi 4t0 2k- sqz t9 ê b=, 9 s8 rqn w[n l3t7 [j-, zk9k0 zti gb=ngzn 8pzd3.

Ix1]X7xe:

***gb3s2 k7nn7**: Ol6wqd87 k7 zw[n ak9pa kqzb= s7 4t0 2k- sqz to k1y8n. (gb9s6bz kqr3 f5n w[n bi w[n xe wa d33d3, t7 w-n t4t4 ê d3, zti 8f[w-sow-p= fun gbogbo zk9k0 4t0 nqz.

***gb3s2 kej8**: Zw[n oluk9pa n7 lqti szlzy3 zw[n ohun t7 w-n ti j4r4 n7n5 2k- sqz sqqj5 gbogbo.

***gb3s2 kcta**: Zw[n am5gbql1gb21 szk9so zw[n ohun 4l0 f5n 4s8 8wqd87, b12 ni 4t0 2k= sqz wq's9pin.

M7m1k=- Wq S9pin:

(i) Ol6wqd87 m5 4t0 ek[sqz gbogbo wq s7 wqzsinmi n7a b9 xe d5p1 c t7n5t7n5 l-w- ak9pa lqpap=. (s8 gb3 0s6bz rzçd2 f5n zw[n ak9pa f5n zk9k0 zti 8faracnij8n.

(ii) Ol6wqd87 m5 4t0 8t-j5 z8lera f5n ti sqz nqz wq s7 0pin.

APPENDIX IV

SUPPORTING DOCUMENTS (ETHICAL APPROVAL LETTERS)

INSTITUTE FOR ADVANCED MEDICAL RESEARCH AND TRAINING (IAMRAT)
College of Medicine, University of Ibadan, Ibadan, Nigeria.

Director: **Prof. Catherine O. Falade,** MBBS (Ib), M.Sc., FMCP, FWACP
Tel: 0803 326 4593, 0802 360 9151
e-mail: cfalade@comui.edu.ng lillyfunke@yahoo.com

UI/UCH EC Registration Number: **NHREC/05/01/2008a**

NOTICE OF FULL APPROVAL AFTER FULL COMMITTEE REVIEW

Re: Effects of Logotherapy and Cognitive Reframing on Blame Attribution among Newly Diagnosed Cancer Patients in Southwest, Nigeria.

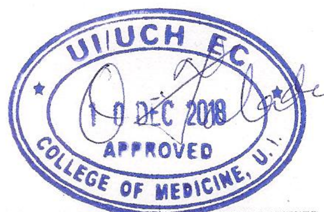
UI/UCH Ethics Committee assigned number: UI/EC/18/0534
Name of Principal Investigator: **Shakirat B. Ibitoye**
Address of Principal Investigator: Department of Guidance and Counselling,
Faculty of Education,
University of Ibadan, Ibadan

Date of receipt of valid application: 10/10/2018
Date of meeting when final determination on ethical approval was made: **N/A**

This is to inform you that the research described in the submitted protocol, the consent forms, and other participant information materials have been reviewed and *given full approval by the UI/UCH Ethics Committee.*

This approval dates from **10/12/2018 to 09/12/2019.** If there is delay in starting the research, please inform the UI/UCH Ethics Committee so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the* UI/UCH EC *assigned number and duration of* UI/UCH EC *approval of the study.* It is expected that you submit your annual report as well as an annual request for the project renewal to the UI/UCH EC at least four weeks before the expiration of this approval in order to avoid disruption of your research.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the UI/UCH EC. *No changes are permitted in the research without prior approval by the* UI/UCH EC *except in circumstances outlined in the Code. The* UI/UCH EC *reserves the right to conduct compliance visit to your research site without previous notification.*



Professor Catherine O. Falade
Director, IAMRAT
Chairperson, UI/UCH Research Ethics Committee
E-mail: uiuchec@gmail.com

Research Units • Genetics & Bioethics • Malaria • Environmental Sciences • Epidemiology Research & Service • Behavioural & Social Sciences • Pharmaceutical Sciences • Cancer Research & Services • HIV/AIDS

FEDERAL MEDICAL CENTRE

Bisi Onabanjo Way, idi-Aba, P.M.B. 3031 (Sapon Post Office), Abeokuta, Nigeria
08095948005-7, 08095947913
e-mail: fmcabk@yahoo.com

Medical Director	Head of Clinical Services	Director of Administration & Secretary to the Board of Management
Prof. A.A. Musa	*Dr. K. I. Hunyinbo*	*Mr. A.O. Vaughan*
MBBS, FWACS, FICS, MSc., PhD	MBBS, FMCOG, FWACS, PGD. THEO. FICS, MBA & MNIM.	B.Ed (Eng) Cert. Health Planning & Mgt. MPA; AHAN

Our Ref: FMCA/470/21 Your Ref: ______ Date: 30th November, 2018

NAME OF PRINCIPAL INVESTIGATOR: IBITOYE SHAKIRAT BOLANLE

TITLE OF STUDY: EFFECTS OF LOGOTHERAPY AND COGNITIVE REFRAMING ON BLAME ATTRIBUTION AMONG NEWLY DIAGNOSED CANCER PATIENTS IN SOUTHWEST, NIGERIA

RESEARCH LOCATION: FEDERAL MEDICAL CENTRE, ABOKUTA

PROTOCOL NUMBER: FMCA/243/HREC/03/2018/19
NREC ASSIGNED NUMBER: NHREC/08/10-2015
FEDERAL WIDE ASSURANCE: U.S/REG NO: FWA/O0018660/02/28/2017
DATE OF RECEIPT OF VALID APPLICATION: 28/06/2018

NOTIFICATION OF EXECUTIVE APPROVAL OF PROTOCOL

This is to inform you that the Federal Medical Centre, Abeokuta Health Research Ethics Committee (HREC) have decided to give chairman approval to your research proposal, after necessary reviews and corrections, under the regulations guiding experiments in human subjects.

This approval is for a Period of one year from 30th November, 2018 to29th November, 2019. If there is delay in starting this research, please inform the HREC so that dates of approval can be adjusted accordingly. Note that no activity related to this research may be conducted outside these dates. No changes are permitted in the research without prior approval by HREC.

All forms and questionnaires used in this study must carry the HREC assigned number and the duration of HREC Approval.

You are to note further that, the National Code of Health Research Ethics requires you to comply with all institutional guidelines, rules and regulation of the codes. Please ensure that any adverse effect from your study is promptly reported to the HREC Federal Medical Centre, Abeokuta.

You are expected to submit a report to this Committee every three (3) months from the date of approval. The HREC reserves the right to conduct compliance visits on your research sites without pervious notification.

Thank you.

30 NOV 2018

Dr. A. S. Adediran
Chairman, Health Research Ethics Committee.

LAGOS UNIVERSITY TEACHING HOSPITAL
HEALTH RESEARCH ETHICS COMMITTEE

PRIVATE MAIL BAG 12003, LAGOS, NIGERIA
e-mail address: luthethics@yahoo.com

Chairman
PROF. N.U. OKUBADEJO
MB. ChB, FMCP

Administrative Secretary
D.J. AKPAN
B.Sc. (Hons) BUS. ADMIN,
MIHSAN

Chief Medical Director:
PROF. CHRIS BODE
FMCS (NIG) FWACS

Chairman, Medical Advisory Committee
PROF. O.A. FASANMADE
MBBS, FWACP, FACE, FNSEM

LUTH HREC REGISTRATION NUMBER: NHREC: 19/12/2008a
Office Address: Room 107, 1st Floor, LUTH Administrative Block
Telephone: 234-1-5850737, 5852187, 5852209, 5852158, 5852111

24th April, 2019

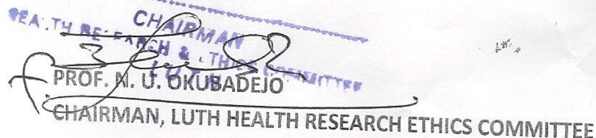
NOTICE OF EXPEDITED REVIEW AND APPROVAL

PROJECT TITLE: "EFFECTS OF LOGOTHERAPY AND COGNITIVE REFRAMING ON BLAME ATTRIBUTION AMONG NEWLY DIAGNOSED CANCER PATIENTS IN SOUTHWEST, NIGERIA".
HEALTH RESEARCH COMMITTEE ASSIGNED NO.: ADM/DCST/HREC/APP/2637
NAME OF PRINCIPAL INVESTIGATOR: IBITOYE SHAKIRAT BOLANLE
ADDRESS OF PRINCIPAL INVESTIGATOR: DEPT. OF GUIDANCE AND COUNSELLING, UNIVERSITY OF IBADAN, IBADAN, NIGERIA.
DATE OF RECEIPT OF VALID APPLICATION: 02-11-18

This is to inform you that the research described in the submitted protocol, the consent forms, and all other related materials where relevant have been reviewed and given full approval by the Lagos University Teaching Hospital Health Research Ethics Committee (LUTHHREC).

This approval dates from 24-04-2019 to 24-04-2020. If there is delay in starting the research, please inform the HREC so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of this dates. All informed consent forms used in this study must carry the HREC assigned number and duration of HREC approval of the study. In multiyear research, endeavor to submit your annual report to the HREC early in order to obtain renewal of your approval and avoid disruption of your research.

The National code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the code including ensuring that all adverse events are reported promptly to the HREC. No changes are permitted in the research without prior approval by the HREC except in circumstances outlined in the code. The HREC reserves the right to conduct compliance visits to your research site without previous notification.



PROF. N. U. OKUBADEJO
CHAIRMAN, LUTH HEALTH RESEARCH ETHICS COMMITTEE

APPENDIX V
PICTURES

[