Psychological factors can affect illness outcome through their influence on behavior when a symptom is discovered, and their influence on behaviors aimed at early detection. Can they, in addition, play a role in the etiology of the disease itself? The ability of the psyche to affect the body and its processes is widely recognized, and the concept of psychosomatic illness reflects this recognition. However, traditionally, the label *psychosomatic* is applied to a limited number of illnesses, such as peptic ulcers and heart disease, and this implies that there exists a category distinct from these to which the label does not apply and in whose case these influences are absent. Such a view is no longer acceptable, and in current theories and research it is assumed that psychological factors play a role in a variety of illness contexts.

**Stress and General Illness Susceptibility**

There have been many attempts to portray the personality characteristics of the "typical" sufferer from various diseases. These portraits have in some cases gained wide public acceptance, but the concept of a relationship between highly specific psychological characteristics of the person and particular diseases does not always meet with empirical support, and the role of personality is, on the whole, today less emphasized in theory and research. One exception is the case of the "coronary prone personality" (Byrne, 1978; Friedman, 1969; Glass, 1977), and there is now increasing acceptance of a "cancer prone personality," of which more will be said later. Recent interest has tended, in general, to shift away from factors defined primarily with the individual and has turned toward the effects of external influences in the form of life events and changes. This shift in emphasis has been facilitated, and encouraged, by the development of an
appropriate questionnaire, the "Schedule of Recent Experience" (Holmes & Rahe, 1967). This comprises a list of life events, ranging from death of a spouse or divorce at one extreme to minor violations of the law at the other, and the subject is required to check those events that he or she has recently experienced. Both desirable and undesirable events are included in this list, since it is the fact of having to accommodate to change rather than wider, evaluative implications of the event that were regarded by the authors as most significant in the etiology of illness. In the published questionnaire, each event has associated with it an estimate of the amount of readjustment that it would require. These estimates were obtained from a group of judges who were asked to give values for each event, on the basis that "death of a spouse" merited 100 such units. Using these weights, the cumulative impact of events experienced within a given time interval can then be calculated for each subject, by summing the Life Change Units appropriate for the events checked. This measure has been very widely employed in either a standard or modified form, and recent life changes have been found both to predict illness episodes in general and to be associated with the onset of specific diseases, including multiple sclerosis, cardiac arrest, rheumatoid arthritis, and tuberculosis (Dohrenwend & Dohrenwend, 1974; Johnson & Sarason, 1979; Rahe & Ranson, 1978; Rabkin & Struening, 1976). The more life change experienced, the greater is the probability of illness onset and the more serious the illness is likely to be. This work has met with a number of criticisms, and it will be useful to review these since many reflect at a general level the methodological difficulties that are met with in psychosomatic studies of cancer.

A major problem is that, not only are the correlations between illness and measures of life change typically low (Holroyd, 1979; Horowitz, Schaeffer, Hiroto, Wilner, & Levin, 1977), but the interpretation of the relationship is problematic. Brown (1974) has pointed to three major sources of possible contamination. First, many studies in the area are retrospective, and illness could bias the way in which life events are reported. People's appraisal of their life style before illness may be distorted by their current state, or they may try to rationalize and justify their illness in terms of what has been happening to them previously. Second, illness can in some cases be itself a cause of life change. Even in its premorbid state, before specific symptoms are recognized, it could have a generalized physical and psychological effect. Problems within a marriage or at work, or changes in sleeping and other habits, might then be in fact an early outcome of the illness and only seem to antedate its onset. Both prospective and retrospective studies can be contaminated in this particular way, and both may be similarly vulnerable to a third difficulty of interpretation. The latter arises from the fact that a correlation between two variables can reflect an influence of another distinct variable on each independently, in the absence of a causal relationship between the original two, and life change and illness onset could vary in parallel because each is in its own right related to an external factor, such as anxiety. Yet another problem, and one not discussed by Brown, is the difficulty of distinguishing between an illness state and illness behavior. People do not always go to see the physician when ill, and it is sometimes other events that act as triggers for help-seeking. A person is more aware of symptoms when under stress,