INTRODUCTION
Over the last two decades recognition that psychological factors play a role in aetiology, outcome and long term adjustment of many physical disorders has grown\(^\text{10}\). In Singapore, recent papers acknowledging such factors cover a range of disorders, for example coronary heart disease\(^\text{10}\), HIV infection\(^\text{10}\) and pain control\(^\text{10}\). In fact all health care professionals - physicians, nurses, anaesthetists, radiographers, pharmacologists, surgeons, physiotherapists - are confronted at some time with the psychological aspects of the problem they are treating. A paper outlining the psychological aspects of breast cancer seems timely given the new Mammography Unit at Singapore General Hospital.

Despite the growing recognition of psychological factors, a fine-grained analysis of the implications for practitioners has yet to be developed. This paper focusses on the issues that face personnel working with breast cancer patients and considers the possible implications for counselling. Three inter-related questions will be addressed:

**Question 1:** How do individuals and their families deal with the crisis precipitated by a serious medical diagnosis such as breast cancer?

**Question 2:** How should health professionals help individuals and families deal with the emotional consequences of invasive medical care?

**Question 3:** What is the relationship between the type of help offered, the type of treatment being conducted, and the type of patient being counselled?

PSYCHOLOGY AND HEALTH
The diathesis-stress account of physical (and mental) illness\(^\text{19}\) points to the breakdown of complex body systems and the large individual differences in coping. A diagnosis of cancer is regarded as a potential stressor, and a common consequence is that patients become overly aware of all bodily functions. This leads to excessive anxiety, avoidable discomfort and sometimes inappropriate medication. It follows, then, that individual differences in coping styles are likely to affect the course of treatment and its outcome. Optimal coping styles can be developed through the use of appropriate counselling, and two epidemiological facts about breast cancer strongly suggest that the need for such help may be common:

**Fact 1:** 1 in 14 women get breast cancer at some time

**Fact 2:** 1 in 21 women die as a result of breast cancer.

Elsewhere, notably in the US, the demand for help with physical disease has stimulated the development of sub-specialties in mental health care such as Behavioural Medicine and Health Psychology. As yet, in the local context, insufficient resources have been allocated for this level of specialisation.

This paper seeks to bridge the perceived gap for professionals who are not trained counsellors but who nevertheless find themselves dealing informally with psychological problems.

COUNSELLING METHODS
The complexity of the relationship between stress and illness is one of the main reasons why there are no simple tried and tested recipes for the would-be counsellor. In a stressful situation, people use a variety of different coping strategies: some worry, some ignore the problem, some seek solitude, some seek family support and some seek religion\(^\text{19}\).

In general, the task of counselling is to optimise the coping strategy, and for cancer patients this would mean helping them find their own means of dealing with the emotional stress of having a life-threatening illness. Six major counselling techniques have been identified for use with breast cancer patients\(^\text{8}\):

- **Directive** - directs patient prescriptively
- **Informative** - gives information to aid understanding
- **Confrontational** - challenges unhelpful thinking and behaviour
- **Cathartic** - permits safe emotional expression
- **Catalytic** - reflectively helps with goals of patient
- **Supportive** - acceptance and empathy for fears and needs

To answer the all-important question "Which method works best?" three contextual factors are relevant:

**When?** - treatment stage

**For Whom?** - individual personality

**What Problem?** - emotional, physical, sexual, anxiety

These three factors will be considered by identifying the potential stages in treatment at breast clinics and the kinds of problems that can be expected at each stage. Staff availability will also play a role in the selection of a counselling technique.

Patients Attending Breast Screening Clinics
There are at least three distinct stages of treatment:

1. **Routine/Repeat Screening**
2. **Pre-operative Diagnosis**
3. **Post-operative Radiotherapy**

Department of Social Work & Psychology
National University of Singapore
10 Kent Ridge Crescent
Singapore 0511

S J Rickard Liow, BSc(Hons), Dip Clin Psych(UK), PhD
Senior Lecturer & Chartered Clinical Psychologist
With three different answers to WHEN?, generalisations about psychological aspects of breast cancer and appropriate counselling techniques cannot be made. However, patterns of coping responses and help needed across the stages can be discerned as outlined below.

Treatment Stage 1: Routine Follow-up Screening

Three types of patients attend routine screening:
(1) asymptomatic, (2) lump assessment and (3) post-treatment follow-ups. Some will hold beliefs that may be irrational and self-blaming. It will be important to understand the beliefs if counselling is to be successful, and to provide information.

The women who request screening without reporting symptoms may come from familial high risk groups. They will understand the seriousness of breast cancer and may already have faith in early treatments. They may, however, exhibit anxiety despite expecting a good outcome. It is worthwhile remembering that being asymptomatic does not necessarily mean good psychological adjustment. Some women live in daily fear of waking up to find a lump, especially when a close relative has died of breast cancer. Regular attendance at clinics does not protect you from getting cancer - it just lets you know you have it very early. Challenging unhelpful thinking and permitting safe emotional expression are likely to be the most appropriate counselling techniques for this group.

Women who have found a lump themselves will often display considerable anxiety. Most lay people believe that most lumps are malignant and some believe they are caused by immoral behaviour or stress. Beliefs can also be influenced by cultural background or religion which, in turn, affect the mode of treatment sought. Some women will have attended traditional healers before the breast cancer clinic, especially if they are more advanced in age. Although there is no clear evidence that stressful life events lead to greater incidence of breast cancer, many women believe stress to have been a factor. They then find themselves in the unenviable position of trying to reconcile two contradictory beliefs. For the symptomatic group, basic information in the form of a leaflet to take home would be very helpful, as well as empathy for their fears.

For the third group, women who are returning for post-op screening one or more years later, anxiety is understandable. Beliefs and knowledge will have been altered by previous treatment experience. Acknowledging the patient's experience (and expertise) will be important as well as assisting with the patient's goal planning.

Treatment Stage 2: Coping With Diagnosis Procedure

Most women understand the significance of finding a lump but many delay seeing a doctor as a result of extreme anxiety and pessimism or denial. Up to 20% delay 3 months or more. This denial is sometimes protective psychologically - it allows you to continue life normally - but, of course, physically it is very damaging to attribute the lump to a "swollen gland" or "pulled muscle". The group who delay coming for help may be in more need of counselling than other patients. One study found that health care professionals (especially nurses) reported lumps later, and the lumps were larger than those of women from other occupational groups. A directive style of counselling may be necessary for patients who fully understand the seriousness of the problem and yet cannot become actively involved in decision making.

Waiting for test results is reported to be the most stressful part of the experience (across all groups 90% are concerned) because patients cannot begin to cope. More women fear cancer and the possibility that other parts of the body have been affected, than fear surgical removal of the lump and/or breast.
example the likely number of sessions/weeks of treatment etc.

Given that the cumulative effects of radiotherapy produce increasingly worse side effects (fatigue, nausea), it is not surprising that most patients dread attending the clinic. Bear this in mind and try to make the waiting time short, and the place as pleasant as possible.

Confidentiality is a major issue for all patients. Be aware that those early in treatment see other patients who look very ill, and they may ask questions about others. Never be tempted to talk about other patients as this will destroy trust. Suggest instead that patients talk to each other and provide a forum for this if possible. Self-help groups provide a range of different people and meet a variety of counselling needs.

**When Normal Coping and Informal Counselling Both Fail**

Routine informal counselling is not always sufficient. Extreme distress, social and sexual difficulties are three times more common amongst mastectomy patients than the normal population; this is also true for hysterectomy patients. Medical personnel are faced with the task of identifying who needs more intensive help from a clinical psychologist, professionally trained counsellor, or a psychiatrist. Psychological problems that are likely to develop are extreme anxiety, depression, body image and sexuality problems.

There is no clear evidence that mastectomy is associated with more anxiety and depression than lumpectomy (38% vs. 32%), but the type of problem may be different[9]. Breast loss per se may not be as psychologically traumatic as was once thought, and relationship problems may not be directly related to radical surgery. Avoiding mastectomy does not mean that psychological well being is preserved - others seem to trivialise the problem if it was "just a lumpectomy" despite follow up chemotherapy and radiotherapy. Fear of recurrence can become obsessionai even in the absence of any physical symptoms. In an extreme form, patients could develop morbid preoccupations, and their whole lives can be taken over by ritualistic behaviours. Relatives and friends will comment on this if asked.

The patient's body image can be badly affected at any age. Sexually inactive women and elderly women must be treated with the same sensitivity as sexually active young women[9]. In other words, age is not an appropriate criterion for treatment decisions. Also, anxiety or dissatisfaction about prostheses is common (33%). Once the breast has been "replaced", there is no guarantee of good adjustment. Body image problems may also be related to fear of the cancer having spread elsewhere, rather than as a direct result of surgical scarring. At least 30% of patients suffer deterioration in sexual interest but, again, this is true for lumpectomy patients as well as mastectomy patients. Benign lumps can also affect libido because patients have been sensitised to cancer and fear recurrence[10]. In sum, many serious interpersonal problems might be avoidable if medical personnel can detect the need for professional help with psychological problems at an early stage.

**CONCLUSION**

When psychological problems have developed beyond the stage when informal counselling and family support are sufficient, referral to a professionally trained counsellor or other mental health worker is advisable. However, much can be done by medical personnel to prevent and alleviate psychological distress arising from physical disorders. This paper has drawn attention to factors which might influence the development of positive coping strategies for many women attending breast cancer clinics in Singapore.

**ACKNOWLEDGEMENTS**

A version of this paper was presented as a lecture to a group of radiographers as part of their course in Mammography at the Singapore General Hospital in July 1991. Both the lecture and this paper draw heavily from Dr Lesley Fallowfield's work in the U.K.

**REFERENCES**