PSYCHOLOGICAL ASPECTS OF BREAST CANCER: IMPLICATIONS FOR PRACTICE IN SINGAPORE

S J Rickard Liow

ABSTRACT

The purpose of this paper is two-fold. It begins with a brief review of the relationship between psychology and health, and the theoretical rationale for different approaches in counselling. The psychological aspects of breast cancer are then described with reference to three different treatment stages, and recommendations are made about informal counselling for patients.

Keywords: *breast cancer, counselling, psychology and health care, treatment stages and coping skills, giving information to patients*

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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(1). In Singapore, recent papers acknowledging such factors cover a range of disorders, for example coronary heart disease(2), HIV infection(3) and pain control(4). 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 interrelated 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(5) 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-specialities 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(7).

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(6):

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/Follow Up 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(7). Challenging unhelpful thinking and permitting safe emotional expression are likely to be the most appropriate counselling techniques for this groups.

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 blame themselves for not dealing with the stress appropriately. 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 person'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(8). 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(8). Again, reassurance in the form of a leaflet containing facts about early detection would be helpful for patients to take home.

Getting a diagnosis and making a treatment plan can be a relief for some women as it marks the beginning of the adjustment period. Most women, however, experience shock and find it difficult to believe. Five coping styles have been distinguished a this stage(7):

1. *Denial* - rather not know any details; reject the seriousness
2. *Fighting Spirit* - positive, hopeful and wanting lots of information
3. *Stoic Acceptance* - quiet acknowledgement and philosophical approach; pointless to worry
4. *Anxious/Depressed Acceptance* - excessive anxiety or depression but manage to carry on with daily life
5. *Helplessness/Hopelessness* - extreme pessimism and social dysfunction; feel helpless and withdraw in preparation for death.

Ability to cope with diagnosis of cancer is very variable and counsellors need to take into account individual patient’s reactions.

Apart from the individual’s personality, much may also depend on the skill of the physician who breaks the news, and the social support of family (especially husband) and friends. When telling patients about the diagnosis, provision of clear, accurate information given in an unhurried manner is essential. However, because of the state of shock, patients may not be able to take it all in.Written information is, again, likely to be helpful. (Up to 40% of spoken information is lost within two hours even without a shock). Key points to remember are:(7)

1. Make sure the patient is fully dressed and seated comfortably. It is humiliating to be naked or still lying on the couch.
2. Try to have a relative or friend present if possible.
3. Tell the good and bad news with regard to the possible spread of cancer.
4. Give simple details about the types of treatment as well as what is recommended.
5. Try to allow patients to feel that they have some control in the decision making process as this greatly reduces helplessness and depression.
6. Consider making a tape recording of the consultation, including diagnosis, details of further scans and treatment options.

In the long term good quality social support is important, but in the short term family and friends may also find it difficult to cope. Depression and anxiety are known to be common amongst relatives, especially daughters. Husbands may have to adjust to the new body image of the wife, and they worry about showing rejection. Family, marital and sexual problems do arise, hence clear information, support and guidance for close family members may be an important way of helping the patient cope.

Treatment Stage 3: Coping With Treatment

The paradox of radiation causing and curing cancer may be difficult for lay person to grasp(7). The process needs to be explained in non-technical terms. The protective clothing worn by radiographers is very alarming for some patients. Radiotherapy may be seen as evidence that surgery has failed. Patients often feel cheated and angry about further treatment after radical mastectomy. Cathartic and supportive counselling techniques will usually be appropriate, but keep the patient informed of progress in treatment as far as possible, for 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(7). 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 obsessional 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(7). 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(7). 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.

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