PSYCHOLOGICAL ASPECTS OF BREAST CANCER

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Breast cancer is a major public health problem among the female population; affecting one in eleven women during their lifetime. Despite the optimistic outlook for survival, breast cancer can significantly alter the quality of life. Although many women are aware of the relatively high incidence of breast cancer, and the importance of early recognition, a very small percentage of women perform breast self-examination. Even if they find a lump, they may wait, rather than see the surgeon due to the fear that they may lose the breast.

The emotional and social problems associated with breast cancer are frequent. To a woman, the breast symbolizes her mothering and nurturing aspects, and it is a part of her sexuality. The thought of breast loss and death brings out emotions of fear, guilt and anger. The constant visual reminder of the illness that accompanies a loss of an external body part can change one's life forever. Therefore, the social and emotional problems should be taken seriously. Several psychological problems reported in mastectomy are: depression and low self-esteem; diminished sense of wholeness, and a sense of asymmetry and body deformity; diminished feelings of sexual attractiveness, and desirability with less femininity; embarrassment and inhibition of attractiveness, and fear of recurrence and spread of cancer.

Distress and anxiety starts when the patient finds, or is informed of, swelling or mass in the breast and when mammography is arranged. Subsequent biopsy further increases the anxiety and apprehension. Once the diagnosis of breast cancer is made, the patient experiences a high level of distress. Avoidance and denial are the common responses used by the patients to reduce the stress, but this may also result in delay in seeking medical treatment. Acceptance of the reality eventually occurs, whether or not the patient goes through the motions of denial or avoidance. Early acceptance will make it easy to cope with long-term stress. Physicians can often help in developing acceptance in patients by simply listening, reassuring, educating and correcting the misconceptions.

The type of surgery a patient has, has a considerable effect on the emotional adjustment she makes. A study comparing the lumpectomy and mastectomy found that both groups of patients reported negative alterations in self image. However, by the second year following the operation, lumpectomy patients showed virtually no impairment of self-image. Breast loss is the central emotional crisis of breast cancer patients, and it has sometimes been equated with castration and a blow to one's sexuality. Women undergoing less radical breast saving operations become better adjusted than women undergoing complete breast removal. Radical surgery may also affect the quality of life, as it interferes with normal social relationship. For some women, the disfigurement appears to be more depressive than breast loss, itself. Patients undergoing immediate reconstruction surgery reported fewer depressive symptoms than those who had delayed reconstruction. All the immediate reconstruction patients reported a return of their pre-operative sexual functioning at an early stage of recovery. Quality of life of patients who choose immediate reconstruction surgery improves significantly. These women describe absence of changes in femininity, self-esteem, body image, feelings of attractiveness and sexual functioning.

The patient suffering from cancer is rarely referred to a psychiatrist; except those who are suffering from delirium or severe depression. The cognitive impairment seen in delirium is a global impairment of memory and thinking. The delirium may be due to cerebral insufficiency which in turn may be caused by metabolic disturbance, hypercalcimea, fever or cerebral metastasis. Delirium may also be caused by chemotherapy or excessive use of analgesis. Delirium generally improves when the underlying cause is corrected. Depression may be accompanied by insomnia, loss of appetite, decreased energy, low self-esteem and loss of libido. Fortunately these patients often respond positively to antidepressant medication and supportive psychotherapy.

Although many research papers emphasize the effects of mastectomy on women, few researchers address the role of the husband. The husband should also be aware of his own fears and feelings concerning his wife's loss of her breast, and her possible death. Husbands should be taught how to become involved in the physical care of their wives, be active in helping their wives regain physical functioning, especially sexual activity, and support their wives effort to regain injured self-esteem. Marriages that suffer because of mastectomy seem to be ones that were uncertain beforehand. Counseling is often helpful.

Psychological evaluation and intervention with breast cancer patients would beneficially occur at the time of diagnosis. Psychological treatment to strengthen or to build coping skills at this point assists patients in decision making and prevents patients in developing severe depression at a later stage. Counseling for the couple is usually recommended, since affectional and sexual disruption may affect the marital relationship.

Most women with breast cancer adjust well to the problems associated with breast cancer. Through public education, women should be informed about the importance of self examination, mammography and safety of operation proceedures. Better education through the media can certainly reduce the stress, anxiety and depression in most women with breast cancer. A small percentage of women may need constant reassurance and guidance from phsycians to build coping skills and maintain affectional, sexual and marital relationships.

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