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☐ Review Article ☐

Psychiatric Care for Patients with Breast Cancer

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Abstract

Psychiatric management of patients with breast cancer, as well as women's emotional reactions to all phases of breast cancer, were reviewed. These patients face two major losses; one is the physical loss of part of the body and a threat to life, and the other is the loss of femininity. The patients are also likely to suffer from various psychiatric problems including anxiety and depression. Oncologists should be alert to each patient's emotional reactions and potential psychiatric problems, and if necessary, should refer them to a psychiarist. A combination of psychotherapeutic, behavioral, and pharmacologic techniques is available for the care of patients with breast cancer. Psychotherapeutic modalities include individual therapy, family therapy, group therapy, and self-help treatment. The author divided individual therapy into general and specific treatment. General treatment deals with a crisis-intervention and cognitive-behavioral approach, whereas specific treatment deals with issues relevant to patients with breast cancer. Some of the therapeutic processes were illustrated in a case report. These guidelines will contribute to the relief and prevention of emotional suffering stemming from an encounter with the most common form of cancer in women. Also, proper and effective care for patients with breast cancer requires combined use of a variety of therapeutic modalities as well as a multi-disciplinary approach including psychiatric care.

Key Words: Psychiatric management, breast cancer, general treatment, specific treatment, therapeutic modalities, multi-disciplinary approach

INTRODUCTION

The psychosocial aspects of breast cancer have received much attention for many reasons, including the high prevalence and mortality of the disease, as well as the psychological effects of surgery on an organ full of accessory meaning (body and self-image, sense of attractiveness, femininity, sexuality, nurturing capacity, and reproduction).[1]

The diagnosis of breast cancer, treatment, and treatment sequelae are major stressors for any woman; however, the psychological impact of the diagnosis and a woman's emotional response vary considerably depending on the medical parameters of the disease (i.e., stage at the time of diagnosis, treatment offered, and complications of treatment), the patient's psychological make-up (premorbid personality and prior personal experience with cancer), coping abilities, and the availability of emotional and financial support.[2]

Those women who reported more stressful life events were at increased risk for the recurrence of cancer and at even higher risk of death from breast cancer.[3]

In a cross-sectional study of 303 women with early-stage breast cancer, 45% of the women had a psychiatirc disorder; 42% had depression or anxiety, or both; there was also minor depression (27.1%), anxiety disorder (8.6%), major depression (9.6%), and phobic disorder (6.9%).[4] Five to 10% of the patients with breast cancer met DSM-IV post-traumatic stress disorder criteria.[5]

There was greater anxiety in women adopting a cognitive confrontational response (withstanding the illness). Younger women may be more likely to view breast cancer as a greater threat to their lives than older women[6] and they may show higher anxiety and greater worry in facing a potential diagnosis of malignancy.[7]

During cognitive-existential group therapy, many of the participants' concerns centered around a sense of profound loss - loss of the sense of a secure future, of good health, of bodily integrity, of self-esteem, of confidence and of mastery over their lives.[8] Their

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findings, derived from qualitiy-of-life instruments used in the study, that women were distressed by hair loss, change of body image, loss of a sense of attractiveness and femininity, and disturbed sexual functioning, buttress the central role of loss[4] and are similar to findings in other cohorts.[9-12]

Many women who have had a mastectomy report continued emotional discomfort when their partner touches their surgical site and reconstructed breast. Some report they are never again able to disrobe in public changing rooms, and many describe being aware that some friends and colleagues never seem to stop scrutinizing their chests - always looking to see what's different.[13]

Like any other kind of cancer, living with breast cancer imposes significant stress on the patient and requires well-developed coping skills. To live with cancer is much more than adapting to the treatments and their various side effects. There are many psychosocial issues to cope with, many of which require much more than coping with the threat to life.[14]

Thus, the author has reviewed psychological reactions to diagnosis, stage of treatment, and recurrence in patients with breast cancer, as well as a variety of psychiatric treatment modalities available for them. Also, the author will illustrate some of the therapeutic processes in a case report.

Psychological reactions to the diagnosis, treatment, and recurrence of breast cancer

When a woman notices a suspicious symptom of breast cancer, her emotional reactions include terror, shock or panic followed by emotional numbness, denial or disbelief as she proceeds with the medical evaluation.[15] When a woman is told that she has breast cancer and that further diagnostic tests, surgery, or other treatment(chemotherapy before surgery) are necessary, her emotional reactions run from sorrow to despair and rage.[13]

Many women who face either mastectomy or limited resection fear dying while under anesthesia and also fear loss of autonomy. Most believe that preoperative waiting will be the most stressful time during the initial work-up, and only later learn that waiting for the pathology report after mastectomy or limited resection is much more stressful. A woman who has a choice between limited resection combined with irradiation or mastectomy is required to confront a different set of fears: how to adjust to the loss of the breast versus how to adjust to living with a breast that has become diseased. They may go into denial while they try to gather information.[13]

A study of women who had mastectomies found 5 stressors: hope for a cure, treatment effectiveness, fear of the unknown, progression of the disease, and pain.[16] On the other hand, studies comparing the psychosocial outcome of mastectomy with that of lumpectomy and radiotherapy revealed some advantages to women treated with breast-conserving procedures in terms of body image, but there was very little difference in terms of psychiatric morbidity or sexual dysfunction.[13]

Many women with breast cancer report that taking chemotherapy seems like adding yet more chemicals to a body that must have been so poisoned that the cancer developed in the first place. The anxiety that was present during the diagnostic work-up continues, as some women with stage 1 breast cancer are asked to choose between chemotherapy or no further treatment. The experience of breast cancer leaves women fearful for their future and worried that they may have made the wrong treatment decisions.[13]

As the chemotherapy session continues, and particularly if postchemotherapy nausea or other side effects of chemotherapy increase, women often come to face the chemotherapy sessions with dread.[13]

Aside from the transient side effects of fatigue, nausea, and vomiting, the most visible and detested side effect of chemotherapy is alopecia. After the loss of their breast, the loss of hair represents for many women yet one more assault on their femininity. These alterations in body image reinforce the view that many women have that they have been mutilated and changed, and serve as visible signs of their private conviction that they are emotionally scarred and forever vulnerable.[13]

For women with estrogen receptor-positive tumors, the use of adjuvant antiestrogen therapy is usually considered. The presence of hot flashes, mood swings, and decreased libido resulting from low levels of estrogen further accentuate the 'out of control' experience associated with breast cancer. For many women, the side effects of chemical menopause come as yet another in a series of 'cruel surprises' following their diagnosis of breast cancer.[13]

Given the wide range of uses for radiation therapy, women's responses vary the same as they do for

chemotherapy. Feelings of claustrophobia are not uncommon as women wonder if they will be able to tolerate both the stimulation and the subsequent episodes of radiation therapy. Patients receiving radiation therapy also report intensified feelings of isolation and loneliness because they are separated from the radiation technician.[13]

For some women, time-intensive radiation therapy represents a daily reminder that they are fighting breast cancer. If women develop metastatic breast cancer, radiation therapy is used to either reduce the metastases or to provide palliative relief from the side effects of the metastases. The heightened awareness of the severity of their illness understandably leads to increased anxiety and worry about death. Not uncommonly, women at this stage become increasingly claustrophobic during the radiation therapy process ("Being in the radiation therapy suite reminds me of being in a coffin.").[13]

As well, the diagnosis of recurrence of breast cancer is an emotionally catastrophic event. Women who experience rapid disease recurrence are frightened. The diagnosis of recurrence emotionally flings a woman back to the beginning. Women describe having virtually the same emotional reactions (terror, shock, and disbelief) they had when they were initially diagnosed, except now they have to prepare for the inevitable.[13]

The site of recurrence significantly affects a woman's emotional burden. Adjusting to local recurrence as the only site of recurrence is emotionally much easier than adjusting to evidence of widespread disease. A woman who has radiographic evidence of bone metastases with no pain or physical limitation has a somewhat easier adjustment than does a woman who is told she has liver or brain metastases.[13]

Psychiatric approaches for patients with breast cancer

In general, the therapeutic approaches used in cancer can be applied to treatment for patients with breast cancer. A combination of psychotherapeutic, behavioral, and pharmacologic techniques is available. Psychotherapeutic approaches include individual therapy, family therapy, group therapy, as well as individual self-help treatment (patient-to-patient volunteers) and self-help groups. Behavioral intervention, including relaxation, biofeedback, systemic desensitization, hypnosis, and guided imagery are helpful for pain and anxiety during procedures, nausea, vomiting, and cancer-related eating disorders. Psychopharmacologic management is effective for anxiety, depression, nausea, vomiting, and insomnia.[17]

Individual therapy can be divided into general treatment and specific treatment for patients with breast cancer.

INDIVIDUAL THERAPY

General treatment

Individual therapy utilizes a crisis-intervention approach in which the therapist: 1) encourages the patient to express feelings; 2) offers support and optimism; 3) clarifies feelings; 4) interprets thoughts in psychodynamic terms; 5) encourages the patient to act on his or her environment; 6) explores the current situation in the context of the past; 7) focuses on specific relevant psychodynamic issues; and 8) limits the duration of therapy.[18]

The therapeutic goal is not just to help the patient adjust to cancer but to utilize mobilized emotion and issues to resolve previously-existing conflicts.[19] The psychotherapy of a cancer patient cannot occur in a vacuum which ignores a direct attack on the primary illness and relies exclusively on a psychodynamic approach.

The educational component of this therapeutic system includes[19]: 1) clarifying the state of the medical condition including diagnosis, prognosis, and therapeutic alternatives; 2) teaching about the effects of the cancer and its treatments; 3) teaching methods for relief of anxiety by relaxation techniques, self-hypnosis, or biofeedback[20]; 4) providing an individualized method of utilizing visual imaging to combat the cancer; 5) supporting compliance with medical regimens; 6) teaching about lifestyle, diet, and exercise; 7) teaching about the common reactions of patients, relatives, and friends to cancer; and 8) self-help groups.

Clarification of the medical condition and related treatments is important. Informed patients have less fear and anxiety, lower levels of stress, and more functioning coping responses.[21] Relaxation techniques help patients feel that they can exercise control over their bodies, as well as relieve pain and anxiety

without extra medication.[20] In addition, a lowered stress level may be associated with an enhanced cancer prognosis.[20,22] This technique may help prepare the patient for visual imaging.[20]

These psychotherapeutic and educational approaches are all helpful in the management of cancer patients. Whether they favorably alter the prognosis of the cancer remains to be seen. However, they definitely lower psychological distress and improve treatment satisfaction and compliance.[23] The techniques of choice with each patient and family depend on individual needs and the modalities available. No single educational or psychological technique has been proven so successful that it should be imposed on every patient. An integrated approach selecting those techniques which are differentially helpful to each individual is strongly suggested.[19]

Cognitive-behavioral treatment can be used for patients with breast cancer. The overall aim of this treatment is to correct deficits in coping, to lower levels of distress, to reclaim personal control, to teach problem-solving methods, and to improve morale. More specifically, it is to influence a patient's coping through educational means.[14]

From several points of view, a cognitive-behavioral approach would be most useful for those patients identified as poor copers. First, it would address the coping deficits of patients. Second, as a short-term device, focused on the "here and now," educational intervention would enable the clinician and the patient to collaborate in promoting the patient's self-control and responsibility for health.

A third advantage of this treatment is cost-effectiveness. Increasing health care costs make it difficult to provide long-term psychosocial support to cancer patients, many of whom will return for multiple treatments and perhaps have several recurrences. A brief problem-solving intervention that is effective can multiply its effect over time. This kind of treatment offers patients an opportunity to learn a method for coping with problems while continuing to live with cancer.[14]

The therapist must be knowledgeable of the medical aspects of the patient's disease, its prognosis, treatment, and common side effects. The therapist must also be flexible in approach; the focus of treatment shifts as the illness changes. Sometimes, psychotherapy is maintained by telephone for those patients too ill to come to the office regularly.[17]

A group of poorly coping patients should be identified. They basically have two main deficits in their coping repertoire. First, they tend to overuse coping strategies that were less effective in bringing about a resolution to problems, though some may bring about a temporary sense of relief, such as getting drunk. Second, and perhaps more important, these patients were unable to generate a number of alternative coping strategies.[14]

Good copers, conversely, were able to try a number of approaches to problem solving and to persevere until something effective was found, and then some degree of resolution was brought about. Also, these patients were able to evaluate and to rank-order their approaches to problem solving without giving each strategy equal weight.[14]

Such treatment begins by focusing on current issues. However, an exploration of reactions to cancer often includes exploration of situations unrelated to illness.[17]

Distressed cancer patients are encouraged to examine their situation, then to articulate their understanding of what might interfere with good coping and to explore options that are within reach in order to find a feasible, satisfactory solution. Good copers are able to face a perceived problem with hope and then imagine a range of consequences that might come about by using different strategies.[14]

Patients are taught how to recognize, confront, and solve commonly-encountered cancer problems. This approach focuses on the process of problem solving and how to carry it out.[24,25] The patients will be offered an opportunity to learn a specific step-by-step approach to problem solving, then to practice the process with the therapist and to apply the procedures to personal problems related to the illness. The therapist attempts to teach and to reinforce active coping skills.[14]

In this intervention, problems are defined, approaches are evaluated and consequences are cognitively considered in order to dissolve self-imposed blocks to behavioral action. The objectives are to strengthen internal controls and to reinforce flexibility about coping strategies, choice of goals, and personal resourcefulness.[14]

The intervention follows the general principles of any short-term psychotherapy. In the first session, the patient is introduced to the program, its procedures, and rationale. A four-session contract is established,

and the patient is told that we will look at common problems faced by many cancer patients and the best way to solve them in the most practical way. Ideas for problem solving are taught and patients are encouraged to practice these skills on their own problems. Relaxation is presented as a time-out procedure for managing stress and for coming up with practical and successful means of problem solving.[26] After explaining the rationale for 'homework' as a way of reaching the goal of self- management, the patient is given a 'homework' assignment for the week which involves daily relaxation training.

At the second session, the therapist checks on the progress with relaxation training. The therapist works with the patient to generate possible strategies for solving his particular problem and ways of establishing priorities among various possible approaches. Homework for the period between the second and third sessions involves more training in relaxation. This is tailored to the needs of individual patients on the basis of their skills and/or deficits in following the procedure. The third session places a heavy focus on problem solving and the process of problem solving is reviewed (Table 1). At this point, the therapist explores current personal problems with the patient and the approach is applied to these.[14]

During the fourth session, the patient and therapist together evaluate the effectiveness of the approach in dealing with problems during the preceding week. The problem-solving steps are reviewed and the patient is given written information about these steps. The need for further sessions is evaluated, and if none is needed, the therapist terminates the formal sessions. Many cancer patients who are distressed believe that change is impossible. However, the philosophy behind this cognitive intervention is that change is possible, that patients can be taught to take steps on their own, and that problems can be reoriented into manageable proportions.[14]

Table 1. Steps in Problem Solving

1. Define the most important problem clearly.
2. Recognize how you feel about the problem.
3. Relax and try not to think about a solution for a while.
4. Consider all possible solutions, even some bad ones.
5. Try to ignore how other people might solve the problem.
6. Evaluate the pros and cons of each possible solution.
7. Arrange the various possible solutions into a list, starting with the least desirable or least practical one.
8. Make a choice.
9. Briefly consider some favorable or positive aspects of the original problem. Can it be thought about differently?

Behavioral techniques include passive relaxation with visual imagery, progressive muscle relaxation, electromyographic (EMG) feedback, systematic desensitization, and cognitive distraction.[27-29] These methods are useful as adjuvant treatments, combined with pharmacologic agents for pain and during chemotherapy infusions.[17]

Visual imaging is sometimes recommended for cancer patients to counter the passivity of the disease and treatment process. This technique can be used by utilizing visual images of their bodies fighting off the cancer. Patients are able to work with specific images devised by the therapist to meet individual needs. Although controversial, imaging techniques help patients feel more in control and less helpless. Patients who have used this technique were found to feel a sense of mastery, assertiveness, and competence.[19]

Antidepressant agents such as tricyclic antidepressants and serotonin-specific reuptake inhibitors (SSRIs) can be used effectively for cancer patients with depression.[17] Anxiety states in cancer usually are treated with benzodiazepines.

In care of the terminally ill, the art and science of medicine and psychiatry are blended. Often the art is strongly influenced by the care-giver's personality, by the history that the family and patient bring with them, and by their psychosocial values and issues.[30] Conflicts that arise regarding decisions about care may lead to requests for psychiatirc consultation and intervention.[17]

Terminally-ill patients are those who have not responded to known curative measures and treatment is aimed at providing maximal comfort during their limited life span. When the label 'dying' is assigned to a patient, attitudes and behaviors of staff and family and friends often assume a different character. These attitudes may tend to isolate or alienate the patient from those whom the patient most needs at that crucial time. We often forget that the person who is dying has not changed, only their life expectancy has changed; and emotional needs only intensify.[17]

Specific treatment

It is clear that psychosocial factors are becoming increasingly important components of the assessment and management of patients with breast cancer. Thus, the development and evaluation of psychological interventions are needed to ameliorate treatment side effects and to enhance quality of life.[31]

Whatever the course of disease, the treatment team should be alert to the ever-present possibility of psychological morbidity, which, if present, requires rigorous evaluation and judicious referral. This referral may not only help to reduce morbidity, but, perhaps more importantly, prevent its dominance over the lives of these women.[4]

In particular, at the stage of hospitalization and operation, the major problems which patients face include the risks of operation, the loss of a breast (including a disturbed body image and reduced self-esteem) and the prognosis with the potential fear of a painful death, followed by anger and acceptance. During this period, a number of psychological problems are likely to occur. Thus, psychiatric care at this stage can be more intensely required than at any other stage. In these circumstances, helping patients to gain support from those closest to them and to confont their situation with a fighting spirit is recommended.[32]

One has to acknowledge that the series of physiological and psychosocial stressors generated by the illness is uninterrupted.

It was reported that the most frequent times of psychiatric referral were during initial treatment or at the time of metastatic or recurrent disease in patients with breast cancer receiving treatment at a radiation oncology clinic.[33] That was because there was a high incidence of major depression in this outpatient breast cancer population. Oncologists frequently fail to recognize a major depression in this patient population. The psychiatric management of these patients is an important part of their overall treatment. Thus, breast care services need to include clinical staff whose job it is to provide suppotive care.[33]

Half of all cancer patients have a psychiatric disorder, usually an adjustment disorder with depression. Effective psychotherapeutic treatment for depression has been found to affect the course of cancer. In three randomized studies, psychotherapy resulted in longer survival time for patients with breast cancer. The four possibilities for psychotherapeutic effects on physiologic change include health maintenance behavior, health-care utilization, endocrine environment, and immune function. Thus, effective treatment of depression in cancer patients results in better patient adjustment, reduced symptoms, reduced cost of care, and may influence disease course. The treatment of depression in these patients may be considered part of medical as well as of psychiatric treatment.[34]

Active confrontation with a fighting spirit may help patients with breast cancer to live longer than surrendering themselves to helplessness and hopelessness.[35] Also, patients who actively confront their illness and the uncertainty that surrounds it have been shown to have better psychological health.[7] In another study, it was found that among coping strategies of patients with cancer, confrontation had a positive effect, but that externalization had a negative effect on the resolution of patients' pending problems.[36]

Billings and Moos found that the use of active, problem-focused therapy and minimal use of avoidance were associated with fewer physical and psychological symptoms and that patients who coped with problem-solving and emotional regulation had less severe dysfunction.[37] Consistent with this, Smith et al. also found that avoidance contributed significantly to psychological disturbance after stressful life events in elderly adults.[38] These findings suggest that counseling and support aimed at promoting engagement, such as actively seeking information about the situation, accepting understanding from someone, and talking to someone about one's feelings may reduce anxiety and depression in patients with a potentially life-threatening illness.[7]

Early work by Greer and Morris found suppression of anger to be associated with a higher risk that a breast lump would be malignant.[39] Anger is found to be associated with anxiety and is frequently directed toward physicians, hospital staff, and families.[40] Anger as well as anxiety and depression should be appropriately managed, sometimes with the help of a psychiatirst.

With breast cancer, a symbol of femininity is compromized. The loss of the breast will interfere with the woman's identity. The psychological impact of breast cancer varies from one woman to another. It depends on the patient's age, personality, real life

experience, social and familial relationships, and psychological or psychiatric history. Every time a cancer is diagnosed, and especially breast cancer in women, the overall psychological history should be taken into account.[41] Then the therapist should help the patient to adjust to surgery and disfigurement, as well as to encourage a return to prior activities without fear of what others are thinking.[14] As later illustrated in a case report, the issue relevant to the loss of femininity can sometimes be overcome merely by the therapist's effort to help the patient express her emotion and encourage the husband's assistance without being confrontational.

In addition, breast conservation surgery can be considered in patients with severe disturbance of body image.[16] Actually, this operation was found to be associated with an improved body image.[4]

In view of readjusting to a normal life, some diversion from the illness and self-validation (or relativizing) may be helpful for patients during a period of convalescence and chemo/radiotherapy.[32]

Among women with breast cancer, marital status and perceived social support were related positively to survival. Maunsell et al. studied 224 women with newly-diagnosed breast cancer and examined the relationship between social support and mortality.[42] Married women had a relative death rate of 0.86 compared to unmarried women over a 7-year follow-up. The death rate was even lower among those who shared with more than one confidant. Thus, the availability of social support through marriage and confidants proved to be a robust predictor of survival.[43]

Social support from a spouse, another intimate, a physician, or by actively seeking social support, has been shown to be related to higher NK activity in patients with stage I and II breast cancer.[44]

Patients with persistent concerns about body image, sexual desire, and sexual function should be referred to professionals who are trained in sexual rehabilitation. Treatment techniques include supportive psychotherapy, behavioral techniques such as relaxation, and gradual re-education in sexual functioning.[17]

During the terminal stage, besides getting support from those close to them, religion may play a critical role in helping patients cope with the process of dying.[32]

CASE

A woman in her late 30s with breast cancer who had undergone radical mastectomy became depressed, along with a perceived loss of femininity and loss of self-esteem caused by the mastectomy. After being discharged from the hospital, the patient was encouraged by her sister to see a psychiatrist. She said, "I can't tolerate living with only one breast." She complained of insomnia and a lack of interest in life. She also showed strong resentment and anger toward her husband, recalling that he had shown little concern about her situation and had returned home late at night a few times several months earlier. Accompanied by the patient, her husband said apprehensively, "My wife is trying to avoid sleeping with me in the same bed." During her sessions, the patient was allowed to vent her emotions, including anger toward her husband's negligence. Antidepressant (fluoxetine) and antianxiety (ethyl loflazepate) agents were administered twice daily. Her anger level was assessed using a hostility questionnaire. She recorded high scores on the anger subscale, saying "I seemed to get sick because I had a bad temper." Then, a variety of coping strategies were reviewed, including a few considered good for her situation that were recommended for her to try. After that time, she began to introspectively search her inner self. She found herself egotistic and self-centered, and she regretted getting into religion externally. In addition, with her husband's understanding of the situation and his active assistance, the patient began to accept her own reality, to forgive her husband for mistreating her, and to regain her emotional stability and self-confidence. The issue relevant to her loss of femininity was not directly confronted by the psychiatrist. Rather, she was encouraged to vent her anger and to organize her real life in a limited condition. Also, the therapist tried to have her husband actively involved in the therapeutic session. Such measures as the therapist's effort and the husband's assistance helped her to overcome the depressed mood caused by loss of femininity and anger toward her spouse, and to return to her routine activities.

Family therapy

Family therapy is also an essential part of this therapeutic approach. The best technique for mo-

tivating the family to become involved in therapy is to point out the need all families have for help in communicating and coping when they must live with cancer.[45] The patient's spouse is helped to come to terms with the reality of the cancer, while providing support and nurture. However, the spouse may first have to vent his or her own fear, sadness, and anger. Relatives of a cancer patient may altruistically deny their own need for help while focusing on the illness and the patient's needs. This can be overcome by educating relatives to relax and cope with the cancer, and therefore the lowered anxiety level will, in turn, lower the stress on the patient.[19]

Work should be done with spouses and other family members to diminish the negative expression of hostility and criticism to the cancer patient and to provide more supportive coping strategies. Reestablishment of the sexual relationship needs to be explored and encouraged.[46,47] Couples and multi-family groups are particularly helpful with cancer patients and spouses as they permit the crisis to be shared with others, allowing for more cooperation in problem solving.[19]

Group psychotherapy

Group psychotherapy may be advantageous for cancer patients, allowing them to receive support from others (patients or nonpatients) who have experienced and have conquered similar problems of medical illness. The cancer patient in a group setting can easily learn that there are a range of normal reactions to illness and a range of healthy adaptive coping styles and strategies which others have employed to make the adjustment to illness easier. Group participation helps decrease the sense of isolation and alienation, as the cancer patient and his family can see that they are not alone in adjusting to illness.[17] Spiegel et al. have reported on their success in leading groups of patients with breast cancer at all stages of disease, ranging from recently-diagnosed patients to the terminally ill.[48] These types of groups, when directed by skilled leaders, can be highly rewarding for many patients. The principles of group therapy for the nonmedically ill person also apply for group therapy with cancer patients.[17]

A randomized trial of supportive-expressive group therapy was conducted for women with metastatic breast cancer.[48] Fifty of 86 women were randomly assigned to weekly support groups which emphasized building strong support bonds, expressing emotions, dealing directly with fears of dying and death, reordering life priorities, improving relationships with family and friends, enhancing communication and shared problem-solving with physicians, and learning self-hypnosis for pain control. Over a 10-year follow-up, there was a statistically significant survival advantage for women in the group therapy condition - they lived an average of 18 months longer.

Self-help and mutual support programs

Self-help and mutual support programs offer alternative support for patients and families. Life crises, such as bereavement, separation, divorce, drug addiction, or life-threatening illness often provide the impetus for individuals to seek emotional support from others experiencing the same trauma. Reach to Recovery was officially sponsored by the American Cancer Society in 1952 to meet the needs of women undergoing mastectomies.[17]

Most self-help support networks for cancer patients work closely with professional medical services, thereby offering social support as an adjunct to medical care. The Patient to Patient Program has been implemented; it is a program in which volunteers visit every newly-admitted cancer patient. Such volunteers help decrease the sense of alienation and isolation of patients because of their unique knowledge and sensitivity, which comes from having had the same experience. In particular, veteran patient volunteers facilitate coping in the newly-diagnosed patient.[17]

Self-help programs staffed by cancer patients provide empathy and teach common reactions shared by cancer patients. These programs provide a great deal of support, information, and role models for successful adaptation and recovery.[19]

CONCLUSION

These guidelines will contribute to the relief and prevention of emotional suffering stemming from an encounter with the most common form of cancer in women. Also, proper and effective care for patients with breast cancer requires the combined use of a variety of therapeutic modalities and a multi-disciplinary approach including psychiatric care.

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