CHAPTER SIX

SUMMARY AND CONCLUSION
6.1 Summary:

6.1.1 Preparatory Step:

In the present study entitled "A Cross-Sectional Study On The Characteristic Changes In Some Psychological Variables Of Breast Cancer Patients Under Different Stages Of Chronicity", attempt has been made to understand the impact of the disease on the patients' mentality and attitudes in relations to self and her social life. A woman, after diagnosis as a Breast Cancer patient, generates within him/her a distress, which disrupts her normal rhythm and quality of life—at the personal and familial spheres. It has a stimulus characteristics of a stressor similar to stressor like sudden demise of a beloved person (McIntosh, 1976).

First two chapters of the present dissertation have dealt with observations and comments relevant to the above impact in the form of psychosocial distress, to collect methodological information helpful to conduct a study with local Breast Cancer patients. Resting on the said information, present study was conducted with local Breast Cancer patients to verify certain research assumptions, by using five much used tests and prescribed procedure. Accordingly, the Third and Fourth Chapters were processed giving due emphasis on the 'psychosocial research implications'.

For want of any published research reports, in this area, with West Bengal Breast Cancer patients, the present researcher has to develop frame of reference to meet her purpose resting on the following research reports:

1. Mutilating surgeries lead to significant changes in interpersonal relationships (Anderson et al, 1985).
2. Some surgeons offer woman with primary breast cancer a choice between mastectomy and less extensive surgery, giving patient a choice between the two — "a choice is psychologically beneficial" (Morris and Ingham, 1988).

3. The Study Group for Psychological Aspects of Breast Cancer (1987) found that Breast Cancer patients had significantly higher somatic distress, psychosocial impairment, poor self-esteem and physical complaints.

4. Individuals normally resort to a wide range of coping strategies to alleviate the resultant stress of traumatic life events. The impact of perception of control on psychosocial adaptation to cancer needs more number of cross-cultural studies (Hilton, 1989; Ell et al, 1992; Thompson et al, 1993).

5. Perceived meanings of people attached to cancer are five 'D's, viz., Death, Disability, Disfigurement, Dependence and Depression (Holland, 1993). The thoughts evoked in persons on first hearing that they have cancer are those related to: fear of physical dependence, fear of treatment, fear of death, fear of pain and fear of recurrence (Latha et al, 1996).

6. The impact of poor quality of life disrupts the patients cognitive harmony and mental balance required for harmonious social relationships. Baider and Kaplan (1997) observed significant positive relationship between intrusion of those imbalanced thoughts and physical distress while insignificant relationship between indifference in social life and physical distress.

7. Several researchers have observed that the issue of carcinogenic personality characteristics yet requires further verification. Similarly, study of relationships between 'locus of
behaviour control' and carcinogenesis yet remain unexplored. The above two areas were not covered by subsequent researches in India (Chaturvedi, 1994; Chaturvedi et al, 1996).

8. "Health professionals, by being informed of coping patients' coping efforts may be better able to predict the women with breast cancer who are at greatest risk for poor adjustment. Efforts to enhance 'approach coping' reduce 'avoidance coping' and foster more active involvement in treatment decision-making — may serve to improve the psychological welfare of these women" (Hack and Degner, 1999).

9. Out of a total of 11,700 registered cases of cancer, "the most frequently reported malignancies were breast (22.72%), followed by uterine cervix (17.5%), gallbladder (6.4%) and ovary (5.8%)") (Sen et al, 2002).

6.1.2 Procedure:

The study has been according to aim, objectives and research assumptions to be verified in the light of Test measures, as described earlier (under Outline Plan, Chapter Three).

Out of a pool of 140 randomly selected Breast Cancer patients from recognised Treatment Centres of Calcutta and suburbs, altogether 100 patients were retained — being matched against six criteria and stratified against three chronicity groups (Chapter Five).

During pre-testing interviews, it became evident that each of them had a history of 'time lag' from 6 months to 1 year range, to get the lump medically examined for diagnosis and treatment.
Through regular visits of treatment centre to spend some time with each patient (in her free time) data were collected by the selected instruments in five to seven sittings. With the help of these patients their junior siblings (N = 100) were also made available to volunteer as participants in some of the test Sessions. It took more than eighteen months to collect data from the two sample groups from different Treatment Centres.

Testwise data were then screened out, processed, tabulated, statistically treated and interpreted to verify research hypotheses and to draw inferences, as described under Chapter Five.

6.1.3 Findings (Salient Features):

(a) The patients admitted for treatment had their family charms as usually while the patients family charm impaired significantly when the sufferings continued over two years without any certainty for cure or control. The findings do not help to retain, here, the first research hypothesis; while revealed sufficient circumstantial influences to generate unpleasant emotions — may be expressed in the form of state anxiety or reactive depression.

(b) Anxiety level of Breast Cancer patients group was found high while there were good number of siblings who were found with higher anxiety. But the 't'-test result (between the group score Means) revealed here a statistically significant difference.
Thus, the second research hypothesis was found here not tenable. The findings spoke in favour of an influence of family environment (where both the patient and her siblings were developed) in generating high anxiety and reactive depression in both the patient and her siblings — particularly applicable to 35 'just diagnosed and treatment started' patients and their siblings. Mean Values of the patients' depression scores and of their siblings depression scores revealed here significant dissimilarity and, thereby, spoke against tenability of third research hypothesis.

(c) The findings helped to identify 75 patients with Breast Cancer and 78 individuals in siblings group with 'internality-externality balance' who may change their respective status under continuous social pressure in very critical life situation. It may be inferred here that familial influence in developing any I-E status in the siblings when they are reared up by same patients in same family environments, particularly (as observed here in seven instances). The said deviation made the fourth hypothesis truly not tenable.

(d) Regarding the Cognitive Style of 'just diagnosed and treatment started' group of patients 'no statistically significant' differences were observed in their pleasant perception of self-image and Social World Affairs; while the perceptions of 'future consequences' of the patients and siblings revealed a statistically significant difference — reflecting the influence of some new information in the patients' cognitive frame of reference about (i) loss of beauty, (ii) broken
conjugal life, (iii) life-long impairment of social status, (iv) economic dependence and (v) low socioeconomic worth. The findings have helped the researcher to retain the fifth hypothesis, qualitatively — claiming similar nature of cognitive style in both patient and sibling groups; while have not supported that tenability quantitatively — as the proportion varied significantly.

(e) The Mean Values in the five different tests, discussed so far, of three stratified groups of Breast Cancer patients (just diagnosed, 2-3 years treated, and over 3 years treated) subjected to ANOVA tests yielded F Score of .01 statistical significance in the areas of Anxiety, Depression, Locus of Control, and Perception of Unpleasant Social World and Future Consequences. The findings here helped to admit significant impact of chronicity over the above areas.

(f) In the present Breast Cancer patient group (N = 100), there were thirteen patients who displayed pleasant cognitive style and twentyfive patients who displayed unpleasant cognitive style. The former group of thirteen patients were characterised here (in the early test reports) with high internal control and high state anxiety; while the latter group of twentyfive patients were characterised beforehand with high external control and high reactive depression.

(g) Coping strategy adopted by the patient sub-groups in seven areas, revealed an apparent dissimilarity — a qualitative
inter-group difference; while three sets of percentage ranks revealed different degrees of positive correlation coefficients (by Rank Order method). Hence, the findings could not help to reject the sixth hypothesis — favouring similarity. Significant influence of negative attitudes found present in them in the form of 'avoidance' and 'given-up attitudes'. Some of them already expressed their stoicistic attitudes and grave mood or 'unconcernedness'. Unresolved conflicts around the 'control' of the disease and 'not recurrence' were found lowest in 'just diagnosed' group of patients and highest in the group of patients receiving treatment more than three years. Predominance of unresolved conflict was found present in the patients of 'just diagnosed' group and 'receiving treatment over two years' group around 'health conditions', 'subjective feelings' and certain 'future consequences.'

(h) Major 'Concerns' of three stratified patient groups are given below in order of proportions:

Group I (Diagnosed And Treatment Started):  
(i) Early cure.  
(ii) Disturbed rhythm of social life.  
(iii) Disfigurement.  
(iv) Socioeconomic worth.  
(v) Socioeconomic independence.  
(vi) Impairment of abilities throughout life.

Group II (Receiving Treatment Over Two Years):  
(i) Early cure.  
(ii) Socioeconomic easiness in life.
(iii) Future certainty.
(iv) Health status in the long run.

Group III (Receiving Treatment Over Three Years):

(i) Cure and control.
(ii) Future safety and security.
(iii) Self-dependence.
(iv) Revival of her role-status and social worth in family and social life.

(i) Breast Cancer patients with usual charms in family life, with high internal control and state anxiety, with conflict resolution through rationalisation (by adopting learned helplessness and faith on God's protection) generally enjoy good social support to keep themselves busy in different activities. They could protect their self-esteem and self-dignity and could win over unnecessary future worries — irrespective of longer duration of disease. In Group I there were 11% patients, in Group II 13% patients and in Group III 12% patients with above description respectively.

Breast Cancer patients with low charms in family life, with high external control and reactive depression, with dominance of unpleasant cognitive style and unresolved conflicts, with given-up attitudes and avoidance attitude generally found badly in needs of adequate social support to keep themselves busy in different activities. They suffer from social deprivation and low self-esteem, dejection and gloomy future perceptions — irrespective of longer duration of disease. In Group I there were 3% patients, in Group II 16% patients and in Group III 18% patients with above description.
The above findings bear significant similarity with the Cluster Analytic study of coping efforts of Breast Cancer patients (Hack and Degner, 1999) while remains open for confirmation by a longitudinal study of the criterion 'patient group' by annual evaluation results from diagnosis to five consecutive years.

6.2 Conclusion :

(i) Background Information :

Cancer is a polygenic disease. Its occurrence remains always a matter of chance or probability at the individual level while exhibit a predictable certainty at the Community level — the risk group. For example, nobody can predict which woman will be affected but interested everybody knows equal susceptibility of the risk group members. It is not the genes of an individual that decide solely the onset and progress of the disease, "but the abstract relationship that the individual bears in the whole environment" (Kothari and Mehta, 1979)*.

To counteract the said mutation, there are three options :

(i) Avoid carcinogens; (ii) Early detection of risk-person and earliest intervention; (iii) Devise treatment methods to alleviate the patient's distress (even if, they are not cured).

*Carcinogenic mutation process, generally, damages some cells - the initiator cells. Initiator cells are to be promoted to develop and expand the cluster of abnormal cells (for malignancy) and its progression by further injury of the cells' DNA - with activisation, governed solely by 'Complete Carcinogens' (like cosmic radiation, X-ray, tobacco smoke). It is a multi-step process, requiring several insults to a cell before cancer develops. Cancer cell is left alone to grow until it kills the host. To prevent the disease, steps be taken to avoid contact with carcinogens (Dasgupta, 2002).
The term 'Cancer' refers to more than 100 forms of the disease. Breast Cancer is one of those forms, where the risk group is women, usually. Does it occur just by switching on a genetic mechanism? The answer is No. Is there any specific Carcinogen? Again, the answer is No. There is no way either to predict whether or how long a woman with breast cancer is going to survive, following diagnosis. Metastatic Breast Cancer generally crosses the boundaries of the breast.

(ii) Observations Over The Findings:

Present group of 100 Breast Cancer patients, hailed from local family environments, and brought up by parents along with their siblings, with the fond hope that they will live a long life, in health and happiness.

(a) They were born and brought up in the midst of a family and community environment which have generated in them number of prejudiced ideas about the causes of the disease and gloomy future consequences; and about its incurability. They believe that bites of scorpion (Cancer) may be controlled in certain cases while the disease lives till the affected person lives. They have not yet heard that:

"Currently, in the 'States, an estimated 3 million Cancer Survivors have no evidence of the disease" (Kaplan and Sadock, 1997). Nor, have read Hoover's comment: "In other words, they estimated that 80% of U.S. Cancer cases were avoidable and preventable" — as observed by famous British researchers Dool and Peto (1981), as those were not

(b) None of these 100 Breast Cancer patients helped the local medical experts for early detection of the disease and its timely surgical intervention (Tiny Cancer, less than 1 cm and strictly localised in a certain small corner of the breast). Quite a few of them, after a vein attempt of self-examination of several months (to conceal the facts), had to disclose their miseries to their spouse or others in family and by that time its progress may reach metastatic stage — awaiting for a fatal consequence.

(c) The group of Breast Cancer patients studied here were all married (as able housewives) and used to live as dependent member of husband or of joint matrimonial family. The news of diagnosis, on the premise of a prejudiced demoralising news (of diagnosis), not only affected married women but also their paternal and matrimonial family members. The more the disease lasted the more their psychosocial distress increased and the charms of social life and interpersonal relation were impaired. The more they became psychosocially withdrawn the more they started to display 'avoidance' behaviour under any pretext.

Chronicity generally made the patients lone, passive, lethargic and overwhelmed with attitudes of indifference;
and they became 'sick people'* expressing 'illness behaviour'. Its characteristic patterns are generally controlled by internal-external control, anxiety-depression manoeuvring, cognitive style and coping concerns, and affinity with spouse, parents and parent-figures, friends and compeers. From the siblings trend of state anxiety and reactive depression one can infer about the personal sensitivity of the patient in this regard.

(d) Birth of a cancer cell in the body and its progress within internal environment of the person concerned reflect stories of several insults to cellular environment — creating a chaos in homeostatic condition of the affected person's physiological and psychological systems of the person — taxing and overtaxing sympathetic systems and adrenal cortex only. Even these two are exhausted, yet 'will to live' remains alive in most cases.

Present researcher has observed to meet them for peculiar demands created by chemotherapy, radiation therapy, surgical operations, once a homeostatic balance is on the way of full restoration it got jeopardised and then started subsequent restorative efforts slowly but with low

*Patients' typical reactions to the experience of being sick is described as 'illness behaviour'. It displays the role that her community ascribes to sick people - like exclusion from usual role responsibilities, her need to get professional care and fund to meet treatment expenses and other maintenance cost. It reflects the cultural beliefs about disease and the way the condition manifests itself. The relation of illness to family processes, class status, and ethnic identity is also important. The attitudes of people and culture about dependency and helplessness greatly influence 'how and what way the sick person generally asks for help and react with others' (Kaplan and Sadock, 2001).
tone of body and mind. The resultant effect was (in absence of any supportive, adjunct therapy to improve psychosomatic tone of the body) manifestation of several health problems, like, adjustment disorder, aggravation of state anxiety, reactive depressions, delirium, insomnia, temper tantrum and pains spreading over the body (sometime unbearable). Desire for committing suicide has been reported by very few patients, suffering over 4 years, with gloomy prognosis, but they were not truly urge-stricken. Reports of pain, depressive mood and pethidine habits were recorded in few cases but they were not truly addicts (No pain, no pethidine).

(e) There was no scope to arrange psychotherapeutic counselling nor group counselling in the present study. During pre-testing interactions with the patients, the researcher has learnt that the patients were more interested in 'activity', earning opportunity, organised recreation and to get guidance from exemplary figures with history of cancer (preferably Breast Cancer) or from professional social workers who could suggest how to make a Breast Cancer patient busy in socially demanded useful activities.*

"I realise that I have known many things from them, yet I have to learn many more to understand their problems."

"I realise that they understand my limitations to do something for their welfare and excused me by not pressing me for anything that they badly need".

*"I realise that I have known many things from them, yet I have to learn many more to understand their problems."
6.3 Concluding Comments:

"The growing incidence of Breast Cancer has been blamed on a growing tendency for late marriage, nulliparity and stress" (Sharma, 2001); and, at the turn of the last century, Breast Cancer was a relatively unusual disease. The emergence of Breast Cancer as a widespread health problem is tied to the extraordinary transformations in women's lives in the modern times (Dasgupta, 2000). The history of maintenance of tumor registry in India is a sad story to tell — its importance was realised as early as 1965, published its last report in 1992 (for the year 1988-1989), and is waiting to publish its current report (ibid).

In modern social life, in women, menstrual cycles start at the age of 12 or 13 resulting about 350-400 opportunities to multiplication of breast cells along with likelihood of genetic accidents — when most Breast Cancers are believed to arise from such accidents. The more modern a society becomes, then, the more crucial becomes the risk factor towards Breast Cancer. Further, in modern community life of an industrialised society, women with the above risk factor in them, remain open to exposure "to several carcinogens at a time" (Schottenfeld and Fraumani, 1996) — from pesticides to cellular telephones (Dasgupta, ibid).

(a) To prevent the spread of Breast Cancer and to uphold the success of cancer therapeutics, steps be taken to prevent contamination of our air, water and food with carcinogens hormone-disrupting chemicals. People have learnt to control their respective allergic symptoms by avoiding foods, materials and conditions which upset their metabolism and
generate autointoxication; but not yet truly learnt to avoid carcinogens.

(b) After each medical therapy, during convalescence, to stabilise the gains of the said therapy, Breast Cancer patients are expected to receive the benefit of other adjunct and supportive therapeutic services, viz., psychotherapy, counselling, group therapy, etc. But, precaution is hardly taken against keeping these patients in an environment where carcinogenic substances have free access to disrupt treatment gains and full benefit of health care programme during convalescence. When medical experts prescribe and arrange during restoration of a cardiac patient a sheltered care in an Intensive Cardiac Care Unit, why not the said experience be transferred for providing a similar sheltered care for the welfare of the Breast Cancer patients — following chemotherapy, radiotherapy and surgical operation.

To quote Ross Hume Hall (1995):

"We have strong scientific evidence about toxic chemicals in the environment that mimic female sex hormones and overload a woman's hormonal system and which is a known cause of Breast Cancer."

As discussed in the foregoing paragraphs, breast cancer risk and its relationship with state anxiety and reactive depression are to be thought or interpreted from different angle. Here, the term risk qualify the career of a 'damaged cell' awaiting to be promoted to a cancer cell under the influence of appropriate carcinogen; whereas high state anxiety or high reactive depression draws other's attention after uncertain or gloomy prognosis of Breast Cancer. Present researcher assumes that to resist cancer growth or its spread over the antidote has to work irrespective of the strength of the immunity power of the affected individuals. As has been observed in treating successfully a case of infective fever by 'tetracycline' (in lieu of penicilnine) or, more directly, the failure of antibiotics to resist virul fever, mostly. So, improving the immunity system by apply­ing psychotechniques for destroying cancer cells seems not possible — as apprehended by some researchers [e.g., Gruber et al, 1988; Kaplan and Sadock (Editors) 2001].

Psychotherapy and Counselling as an essential adjunctive therapy can be effectively utilised (as used in rehabilita­tion of handicapped and drug addicts) to tone-up the mind of Breast Cancer patients to gain self-worth, self-confidence, self-reliance, restore self-esteem, overcome conflicts and complexes for enjoying active life, by setting aside cancer-caused disabilities. As expressed by a Breast Cancer patient: "It is an accident. Can't be helped. Now it is my
breast cancer. Doctor is trying his best to tackle the disease. Why should I interfere?"

### 6.4 Suggestions:

(i) Breast Cancer Literacy Drive need to be started involving Secondary Girls' High School population, Higher Secondary Girls School population, Graduate and Postgraduate level population (both boys and girls) of West Bengal -- to counteract prejudiced idea about the disease, to understand the implication of late marriage, multipartity, and stress in a female citizen's life along with the sources of breast cancer promoter carcinogens.

(ii) Paying due regards to both 'experience-based practice' (E.B.P.) and 'evidence-based practice' (Ev.B.P.), the researcher thinks time has come to consider Breast Cancer as a variety of consumptive disease and, accordingly, the Breast Cancer patient may start her journey from the O.P.D. of a Treatment Centre, but she must get opportunity to spend her days (from time to time) in a properly built Sanatorium.

Resting on the statistics, upto 1999 December, of Breast Cancer patients in Eastern India (Urmī Sen* et al, 2002) it can be said that provisions be made instantly in Eastern India to set-up at least 10-15 Sanatoriums or

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*Completed the report, published it and ended her life as a Cancer patient.
Resorts to accommodate 2,640 cases approximately (time to time) — following each Medical Treatment Exposure under convalescence stage.

As the said Sanatorium will be interested to deal with the welfare and quality of life of a 'wholeman' so its programme will offer each patient a busy daily work schedule for restoring back and upholding her capabilities for social worth and competence — consisting of programmes for (i) learning, (ii) earning, (iii) recreating, (iv) self-realising, and (v) enjoying psychological support service and (vi) participating Group Therapy and Team Games.

(iii) Attempts be made to collect 'control and curability statistics' and circulate that to risk population for defending their prejudiced idea in favour of 'incurability hypothesis'.

(iv) India is a 'welfare state'. Accordingly, a Government policy be adopted to subsidise the Treatment costs of Breast Cancer patients, registered for their life-long medical and health care in any recognised Centre (outdoor and indoor wings), against a National Cancer Registry enrolment number.

(v) From 'mental health care' view points of Breast Cancer patients screening programme needs to be arranged at the time of O.P.D. registration to differentiate between (i) patients with a history of mental disease and (ii) patients without a history of mental disease. Treatment
plan, prescription of drugs and specific adjuvant health
care services are to be finalised and followed-up accord­
ingly. For example, Why sleep disturbance? Is it a
prodromal insomnia symptom? or a reactive sleep distur­
bance to be cured by psychotherapeutic counselling with
placebo? Because during drug trial, administration of
anti-carcinogenic and psychiatric drugs simultaneously many
causes unnecessary complications. No treatment centre be
allowed to function without a clinically specialised psycho­
logist and a consultant psychiatrist.

(vi) Each Treatment Centre must be attached with a recognised
Sanatorium (nearest to the Centre) to recommend the case
for admission in this Centre, at the earliest opportunity.

6.5 Unattended Areas Of The Study Requiring Further Attention:

(i) The Breast Cancer patients (matched sample) studied here to
understand the characteristic changes in some selected
psychological variables need further study with unmarried
patients; high and low economic group patients; and higher
education group patients to compare the results.

(ii) The effect recorded here, in the cross-section of three
groups of patients with longer period of suffering, need to
be verified by a longitudinal study with small group of
sample from the stage of diagnosis, sequentially, after
every six months upto 4 years, at least.
(iii) Attempts be made to identify Breast Cancer patients with a history of mental disease and without any history of mental disease and study by using same instruments to compare the characteristics.

(iv) Effect of psychotherapeutic counselling be studied during Longitudinal study, sequentially, as stated under 6.1.

(v) Effect of different medical therapies (at different stages) on the mind of Breast Cancer patients with longer period of sufferings need to be studied in the light of changes in their 'cognitive styles' and 'coping concerns' taking sample from different sample strata, as described under 6(i), to understand their barriers against return to normal social life and family life and the areas where counselling is most and more needed for restoring interpersonal relations.

(vi) Present study has no tall claim. It is an initial study with local patients. The findings remain open for further verification and precision to be adopted in future studies.
Further References:


Chaturvedi, S.K. (1994). Exploration of Concerns and Role of Psychosocial Intervention in Palliative Care - A Study from India. Annals Academy of Medicine, Vol. 23(2).


