CHAPTER ONE

INTRODUCTION
Scientific explanations of mental abnormalities and clinical aspects of personality manifestations in its sojourn of intellectual odyssey had been caught up in a state of Scylla and Charybdis — mindless materialism on the one side and disembodied spiritualism on the other. By the end of 19th Century, psyche or mind got its genetic heritage. Later, after Freud, its biogenic existence was protected in the cradle of libido development within a grid of ego-external world, love-hate, and narcissistic-anaclitic disposition. Thus, the scientific explanations drew the attention of a psycho-physical reality — two interdependent biogenic entities growing and functioning upon a common platform — the environment, a composite of physical, psychological and social environments. Researchers, later, tied the said interdependence by an objective causal relationship.

Thus, it is of more than mere casual interest to examine the scientific literature on the effects of mental events on physical processes. What are the evidences to indicate that mind can influence the course of a disease in the body or vice versa? The brain and CNS is such a complex and elegant organic system that it would be strange indeed if it has no role to control behaviour and composite processes for the survival of self and preservation of race.

1.1 Cancer Or Carcinoma:

Cancer is a group of diseases that occur when cells become abnormal and divide without control or order. Every organ in the body is made up of various kinds of cells. Cells normally divide in an orderly way to produce more cells.
only when they are needed. This process helps to keep the body healthy. If cells divide when the new cells are not needed, they form too much tissue. The mass or lump of extra tissue, called a tumor, can be benign or malignant.

**Benign tumors** are not cancer. They can usually be removed, and in most cases, they don’t come back. Most important, the cells in benign tumors do not invade other tissues and do not spread to other parts of the body. Benign breast tumors are not a threat to life.

**Malignant tumors** are cancer. The cancer cells grow and divide out of control. They can invade and damage nearby tissues and organs. Also, cancer cells can break away from a malignant tumor and enter the bloodstream or lymphatic system. That is how breast cancer spreads and forms secondary tumors in other parts of the body. The spread of cancer is called metastasis.

Cancer is a group of diseases that for centuries has struck fear in the hearts of people. Its previously certain fatal outcome, absence of known cause or cure, and association with pain and disfiguring lesions made it particularly frightening and loathsome. Physicians long avoided telling patients they had cancer, believing the diagnosis would be too painful to hear. The family colluded with the physician to keep the diagnosis a secret from the patient.

Several factors have contributed to attitude changes in the United States. The American Cancer Society, founded in 1913, began to educate the public about early diagnosis and treatment. In the 1950s and 1960s, physicians and patients became less pessimistic about cancer as radiation therapy and chemotherapy altered the pattern of outcome for several neoplasms in children and
young adults. Clinicians began discussing more openly all aspects of the illness with patients and families.

The hospice movement in Europe and the pioneering work of Dr. Elisabeth Kubler-Ross in the United States led to a re-examination of and improvement in care for dying patients. Far more attention was given to symptom control, particularly pain. Patients who wished to discuss their fears of advanced cancer and death could do so because the situation's reality could be acknowledged.

Cancer's transition, from a group of neglected and hopeless diseases to one of potential cures, increased treatment efforts, and extensive research generated more interest in the psychosocial aspects of cancer patient's life.

1.1.a Psychosocial Adaptation Of Cancer Patients:

Persons who receive diagnoses of cancer exhibit characteristic normal responses. A period of initial disbelief, denial, or despair is common. In the second phase, patients report anxiety, depressed mood, anorexia, insomnia, and irritability. The usual daily activities are impaired and intrusive thoughts of the illness and uncertainty about the future are present. Adaptation usually begins after several weeks as patients integrate new information, confront reality issues, find reasons for optimism, and resume activities. It has been observed that during psychosocial adaptation to cancer, the following factors play influential role:

(a) **Medical**: Tumor site, stage at diagnosis; predicted outcome, symptoms, functional loss; treatments required; rehabilitation available; clinical course of illness; and associated medical conditions.
(b) **Patient-related**: Level of cognitive and psychological development; ability to cope with life crisis; emotional maturity and ability to accept altered or unachieved life goals; prior experience with cancer; concurrent life crisis, and family or social support.

(c) **Societal**: Attitudes toward cancer and prognosis; stigma associated with diagnosis; and health care policy (Insurance, disability, protection from job discrimination).

Holland (1993) has summed up the meanings attached to cancer as five D's: Death, Disability, Disfigurement, Dependence and Disruption of relationships. A study done at the Regional Cancer Centre, Trivandrum, India (Latha et al., 1996) has revealed that the thoughts evoked in persons on first hearing that they have cancer are those related to: Fear of physical dependence (98%), fear of treatment (80%), fear of death (64%), fear of pain (62%) and the fear of recurrence (62%).

The patient's perception of the disease, its manifestations, and the stigma commonly attached to cancer contribute to these responses. For adults, fear of a painful death is a primary concern. Most children fear serious illness because of separation from and loss of loved ones. All patients fear the potential for disability, dependence, altered appearance, and changed body function. The new role of being sick or different involves a change in nearly every aspect of the adult's or child's life. The fear of being abandoned by family and friends is common.

There have been tantalizing suggestions in the literature that mental events, such as the expression of anger, are non-randomly related to cancer
diagnosis and progression. In 1975, Greer and Morris found that women with malignancies at breast biopsy had more difficulty expressing anger than those with benign lesions. The mood assessment was performed before the patients had the results of the biopsy, also the difference in prognosis could not account for the psychological differences. In 1979, Derogatis et al reported that cancer patients who were rated by the medical staff as less cooperative lived significantly longer. This finding was complicated by the fact that the long-surviving group had significantly less radiotherapy prior to the study.

Greer et al (1979) found that cancer patients with "fighting spirit" survived longer. These earlier studies received support from Goldstein and Antoni (1989), who found more repressive coping styles among breast cancer patients as compared with controls, and from Hislop et al (1987), who found that extraversion and social activity were predictive of longer survival among breast cancer patients. However, unlike earlier work, they found that low, rather than high, levels of anger predicted better outcome. Temoshok et al (1985) found that relatively cooperative, unassertive malignant melanoma patients had more unfavourable prognosis. Temoshok (1985) also found that patients with melanoma who self-reported more psychosocial distress had faster disease progression. Ramirez et al (1985) reported that severe stress from adverse life events was significantly associated with an increased risk of breast cancer relapse.
1.2 Breast Cancer - Ductal And Lobular Carcinoma:

Each breast has 6 to 9 overlapping sections called lobes. Within each lobe are many smaller lobules, which end in dozens of tiny bulbs that can produce milk. The lobes, lobules, and bulbs are all linked by thin tubes called ducts. These ducts lead to the nipple in the centre of a dark area of skin called the areola. Fat fills the spaces around the lobules and ducts. There are no muscles in the breast, but muscles lie under each breast and cover the ribs.

Each breast also contains blood vessels and vessels that carry colourless fluid called lymph. The lymph vessels lead to small bean-shaped structures called lymph nodes are found in the chest. Lymph nodes are also found in many other parts of the body.

There are several types of breast cancer. The most common one begins in the lining of the ducts and is called ductal carcinoma. Another type, called lobular carcinoma, arises in the lobules. Other cancers those begin in the breast are rare.

When breast cancer spreads outside the breast, cancer cells are often found in the lymph nodes under the arm (axillary lymph nodes). If the cancer has reached these nodes, it may mean that cancer cells have spread to other parts of the body — other lymph nodes and other organs, such as the bones, liver or lungs.

*Present study has been conducted with 100 Breast Cancer patients, so an attempt has been made here to highlight more information relevant specially to Breast Cancer and its Victims.*
Cancer that spreads is the same disease and has the same name as the original (primary) cancer. When breast cancer spreads, it is called metastatic breast cancer, even though the secondary tumor is another organ.

Doctors can seldom explain why one particular female gets breast cancer and another why not. It is clear, however, that breast cancer is not caused by bumping, bruising or touching the breast. And this disease is not contagious; no one can "catch" breast cancer from another person.

By studying large numbers of women all over the world, researchers have found certain risk factors that increase a woman's chance of developing breast cancer. There may be other risk factors we don't know about. Some known risk factors can be avoided, but many cannot. Having risk factors means having a higher-than-average chance of getting this disease. However, studies show that most women with known risk factors do not get breast cancer. And many women who get breast cancer have none of the risk factors we know about, other than the risk that comes with growing older.

The following are some of the known risk factors for breast cancer:

1) **Age**: The risk of breast cancer increases as a woman gets older. Most breast cancers occur in women over the age of 50; the risk is especially high for women over 60. This disease is uncommon in women under the age of 35.

2) **Family History**: The risk of getting breast cancer increases for a woman whose mother, sister or daughter has had the disease. The woman's risk increases more if her relative's cancer developed before menopause or if it affected both breasts. About 5 per cent of women with breast cancer have a
hereditary form of this disease. These women usually develop breast cancer at a younger age before menopause, and they have multiple family members with disease.

iii) **Personal History**: The risk of breast cancer is greater than average in women, who have had lobular carcinoma *in situ*. About 25 per cent of women diagnosed with this condition develop invasive breast cancer. Also, women who have had breast cancer face an increased risk of getting breast cancer again. As many as 10 to 15 per cent of women treated for breast cancer for ductal carcinoma *in situ* get a second primary (new) breast cancer later on.

Other risk factors for breast cancer include starting to menstruate at an early age (before 12) or having a late menopause (after 55). The risk is also greater in women, who had their first child after the age of 30 and those who never had children. These factors are all related to a woman's natural hormones. At this time, no one knows whether the risk of breast cancer is affected by taking medicines those contain hormones (either for birth control, to treat infertility, or as estrogen replacement therapy to control symptoms of menopause). Scientists hope to find the answer to taking part in hormone-related research.

Some aspects of a woman's lifestyle may affect her chances of developing breast cancer. For example, some studies point to a slightly higher risk of breast cancer among women, who drink alcohol. The risk appears to go up with the amount of alcohol consumed.

Scientists are trying to learn whether having an abortion or a miscarriage increases the risk of breast cancer. Thus far, studies have produced conflicting evidence, and this question is still unresolved.
Older women, who are overweight, seem to have a greater risk of breast cancer. Although the possible link between diet and breast cancer is still under study, some scientists believe that choosing a low-fat diet, eating well-balanced meals with plenty of fruits and vegetables, and maintaining ideal weight may lower a woman's risk. Also, recent studies suggest that regular exercise may decrease the risk of breast cancer in younger women.

1.2.1 Psychosocial Factors:

Although some researchers are satisfied regarding an insignificant role of psychosocial variables in the development of breast carcinoma, there are researchers who have remarked that the evidence to date has not been of sufficient quality to constitute a "fair test" of this hypothesis.

One of the main factors studied and the focus of the current report is personality. The "Cancer Prone Personality" theoretically predisposes some individuals to develop cancer and experience a more rapid disease progression (Temoshok, 1967). The three components of this personality type are: 1) a distinctive coping style characterized by abrogating one's needs in favour of the needs of other; 2) difficulty in expressing emotions; and 3) an attitude of helplessness or hopelessness. The empirical evidence to support this theory in the case of breast carcinoma is equivocal. To our knowledge much off the research focuses on emotional suppression or emotional control. Six of 13 studies in this area reported negative results (Hahn and Petitti, 1988; Bleiker et al, 1996; Kreitler et al, 1993; Edwards et al, 1990). Of the seven studies reporting positive results (Grassi and Capp411ari, 1988; Greer and Morris, 1975;
Scherg et al, 1981; Cheang and Cooper, 1985), only two were adjusted for age; one of these had a very poor response rate, whereas the other found anger repression to be associated with the development of breast carcinoma only in patients age below 50 years.

Renewed debate regarding the association between stress and the development of breast carcinoma has coincided with the recent publications of three studies, two of which report significant association between antecedent life events and breast carcinoma and a third that found no association (Chen et al, 1995; Roberts et al, 1996). The series of commentaries concerning the topic of stress and the development of breast carcinoma also reflect the inconsistency of research findings (Cassileth, 1996; Burke and Goodkin, 1997). Assessments of existing findings include the opinion that stress or other emotional factors play a "relatively minor" role in the etiology of breast carcinoma (Cassileth, 1996), that the question is clinically insignificant, that major life events in the presence of other psychosocial factors increase the risk of breast carcinoma (Faragher and Cooper, 1997), and that an adequate test of the hypothesis has yet to be performed (Burke and Goodkin, 1997). Despite this, there is widespread belief in the community that stress is a risk factor for cancer, in particular breast carcinoma.
1.3 Mental Dispositions Indulgent To The Growth Of Breast Cancer:

(a) Pre-diagnostic Mental Stress:

Awaiting the diagnosis of possible breast cancer can be an extremely stressful time for any woman. Worry about the possibility of breast cancer is a terrifying prospect for most women for several reasons: possible mutilation, physical pain, loss of health, loss of love, loss of control over her life, and premature death.

A woman's initial psychological stress usually occurs when she first detects one of breast cancer's warning signs — a detectable lump, a change in appearance, etc. At this point, the woman bases her reaction on what she knows about breast cancer at that point in the time. This base of information could be correct or inaccurate. In addition, she may have fears and fantasies that are based on fact or misconception.

If we divide her possible reactions into two general types, they would be acceptance and/or denial. Each woman reacts differently when she confronts a symptom of the disease, and this reaction is shaped by many things in her personal history. Past coping skills and current social supports are key variables in terms of how one reacts to this life event. Women, who recognize that they have one of the potential warning signs of breast cancer, are more likely to seek prompt medical advice. Only one in four woman realizes that the majority of breast lumps are not cancer. Therefore, many women may be reluctant to seek clarification. Consequently, many women initially deny the symptoms, and, therefore, delay seeking medical advice. Once again, she can be influenced by fears and fantasies she may have about the disease, and these
can be based on fact or misconception. Some of the possible reasons are: insensitivity to breast changes, ignorance of the significance of a breast lump, hope that the lump will go away, lack of pain, fear of cancer, and financial concerns, to mention a few.

For whatever reason, the woman's fear or fantasies might prevent her from seeking prompt medical advice, these women are sometimes more tense, angry, tired, and confused. Often this translates into less satisfaction with the doctors when the doctors are finally consulted. This psychological stress continues until medical advice is sought and a diagnosis is received. Prolonged denial can also lead to other psychological problems in adjusting if cancer is confirmed. Unfortunately, prolonged delay can adversely affect the prognosis if it is indeed cancer.

(b) Post-diagnostic Mental Stress:

Regardless of how well-prepared a woman may think she is for a diagnosis of breast cancer, the actual confirmation, if there is one, is generally very upsetting. Patients usually respond to the news by being shocked, terrified, numb, panicky or stunned. Such a reaction is normal. Once one moves beyond their initial reaction, questions of treatment and coping with the future replace shock and denial. One's fears and fantasies about this disease can become more disturbing than the facts, and can impact upon the woman's psychological response to the diagnosis.

A diagnosis of cancer evokes several other reactions. In addition to fear and grief, these are: guilt, anger, shame, helplessness and sometimes depression. Her concerns may be: whether she will live or die, whether the
treatment will be painful, whether she can rely on her diagnosis, whether she is going to suffer, worries about other members of her family as well as her ability to take care of them, job concerns, and even whether others will lose respect for her or begin to emotionally withdraw.

It is important for the woman to discuss these feelings with someone. She can discuss it with family members, a doctor, friend, or with someone who has gone through the same thing. Verbalising one's feelings lessens the chance that she will become depressed, and it helps her to cope with the situation.

(c) Mental Stress During And After Treatment:

The horror of losing a breast, a feeling that the femininity has been violated, are psychologically extremely traumatic events for a woman.

Mastectomy patients have many concerns, some of which include threat to life, fear of pain, fear of a recurrence, physical rehabilitation, financial support and insurance, side effects of adjuvant therapy, reconstruction and cosmetic concerns, sexual attitudes and behaviour, feelings of devaluation or loss of femininity, relationships with family members, possible pregnancy and sterility, to mention a few. These concerns are normal. It is important too for patients to discuss these fears and concerns. Some women try to be stoic and repress these feelings, but they are then denied a necessary outlet for their feelings. Family members who maintain a constant posture of rigid optimism cut off a necessary path for the patient to discuss her fears and concerns. Expressing feelings of anxiety or depression about breast cancer can actually be a part of an effective coping behaviour.
Many of the emotions seen in earlier phases reappear during this time. Denial can return, and though this may be useful for a short period, when it does not end, it can signal psychological problems or the onset of depression may begin to surface. Psychologically speaking, after surgery, chemotherapy and/or radiation, depression is normal and expected. Caregivers and treatment structure are no longer a daily part of one's life. Patients can become fearful and anxious, develop sleep difficulties and experience reduced interest and pleasure for two to six months. Anger can be a problem if it is repressed instead of expressed. Self-image can be affected by the alteration of one of the main symbols of self-image. A woman who defines herself primarily in terms of her body and appearance may now feel unattractive, mutilated, repulsive or even unclean. Guilt and shame can continue as before when the patient may have felt that the cancer was due to improper eating on her part etc., and now may be aggravated by her feeling that the loss of a breast is not trivial, when others may present it as trivial compared to her life. The patient may not feel as "lucky" as others tell her she should. Depression and grief are both common emotions. Grief is felt in relationship to loss of her healthy self, her breast and her world. Grief and depression can both occur normally for brief periods after the patient has gotten on with life.

Radiation carries some special fears and misconceptions. Some patients worry that the radiation will itself cause cancer, or it will burn and disfigure them. Some family members mistakenly fear that the patient might be "radioactive" and, therefore, dangerous to be near. None of these are true, but the fear and anxiety may persist. The silence and loneliness of the treatment can be scary as well. Adjuvant chemotherapy has its own set of fears and anxieties. It can cause fatigue, nervousness, irritability, tearfulness,
depression and sudden mood swings. One common side-effect is hair loss, and while this is not a major medical problem, it is a big psychological issue. Hair loss can be very distressing, and is normal. As the course of chemotherapy continues, patients might become somewhat apprehensive as to whether or not it is working. During this period, as well as on an ongoing basis, support from family members and friends is very important, as is expressing feelings.

(d) Mental Stress Of Family Members Of Breast Cancer Victims:

A diagnosis of breast cancer obviously affects not only the patient, but her family members and friends as well. To further complicate the situation, how the family members and friends deal with the disease impacts on the ability of the patient to cope. The stage of the patient's breast cancer disease determines the degree of seriousness of her diagnosis, and in turn, how it impacts the family and what adjustments and coping skills are required.

On the part of family members and close friends, this can be quite challenging even for families accustomed to communicating well. Fear of death or loss of a loved one often inhibits good communication. A falsely cheerful attitude only represses the fear, anger and concern being experienced. A lack of good communication or a constantly cheerful attitude on the part of loved ones can make matters worse. Anger, though a common reaction, can cause feelings of guilt and helplessness. Children can become hostile as they are often confused and frequently not informed. Extra responsibilities can make all members of the family resentful, which can lead to further feelings of guilt and shame for having felt that way in the first place.
Next to the patient, the partner, if there is one, is most profoundly affected. Suddenly they are shouldering extra responsibilities, while they are dealing with shock and fear of losing their mate. Generally, the mate copes better than the patient, but they may well have their own periods of depression.

Young children are especially affected by breast cancer, since they fear separation from their mother. Young children especially fear separation from their mother, while the mother is in the hospital, they are likely to become most afraid. The child may also be feeling guilty about the mother's illness, or may become angry, and then feel guilty over having such feelings. Common reactions in children include: anger, depression, and sadness, while more serious reactions include recurrent nightmares, extreme withdrawal, extreme weight loss or gain, regressed behaviour (For example: loss of toilet training), unprovoked rage, or a sudden drop in academic performance. While so much attention is being paid to the patient, the child might feel displaced and attempt to gain attention.

Adolescent children pose special problems, even when they are fully informed about the disease, because they suffer more and often exhibit more behavioural problems during a parent's illness than younger or older children.

Adolescent daughters have special problems. They may be expected to take over the mother's role, causing her to repress her own needs.

Adolescent sons, surprisingly, have the most trouble dealing with breast cancer of anyone in the family. They are frequently given the least attention.
of any children. Boys in this age group are usually embarrassed to discuss 
sexual issues, and breast cancer is viewed as such an issue.

(e) **Conjugal Relational Stress Of Breast Cancer Victims**:

All human beings are innately sexual, and the need for sexual expression
does not cease when a person develops cancer. If anything, their needs for
physical intimacy and human warmth increase. Although some may minimize the
importance of this compared to life and death, it can be a very critical element
in the patient's quality of life. Losing one's breast is a symbolic loss that
needs to be grieved. Relearning to be intimate is a challenge for these women,
as well as her sexual partner. It can bring them closer together or pull them
apart. Even though she may feel frightened, awkward and uncomfortable with
her new body image, it is important for her to own her feelings, whatever they
may be, in order to move forward. Self acceptance, emotional support and
affection are the roads back to intimacy.

Breast cancer threatens not only life but the core of self-image for women.
Treatment means mutilation of and an assault on their sexual being. Breast
cancer can cause a loss of confidence about sexual attractiveness, changes in
body image, and apprehension about intimate relationships. Mastectomy can be
the cause of some of the most serious adjustment problems.

A woman might feel undesirable and avoid intimacy, fearing that her
partner will be uninterested in her. This can lead to behaviour, that in fact,
cause the very reaction that she does not want from her partner. Keep in mind
that virtually all forms of treatment can reduce energy and cause listlessness
for some period of time. Chemotherapy can cause nausea, vomiting and hair
loss, and can cause uncomfortable mouth and vaginal lesions. Indelible markings on the breast for radiotherapy can be a constant reminder of the disease, and her stigmatised life.

1.4 Frame of Reference For Present Study:

Reviewing the literature related to breast cancer, the researcher has observed that inadequate attempts have yet been made by the local professionals for retrieving and reporting cognitive appraisal data of the breast cancer patients. Cognitive approach explores individual's perceptions, interpretations and evaluations as the central mediating factor in adjustment to uncertainty and threat. It is not the situation per se, but the implication it has for the person concerned determine how that person feels and behaves. Diagnosis of cancer generates in the mind of a patient a fear of her social devaluation; and its nature and intensity show very wide range of variations - though they have diagnostic and therapeutic similarities. One sees cancer with extreme pessimism, as a death sentence; while the other with high optimism believes that the treatment will be successful and socially gainful. In order to understand the patients' experience and reactions it is necessary to know the individuated meaning that cancer holds for them. Personal meaning plays a vital role in personal-social adjustment. Not too many studies have tried to explore these key issues. These facts have helped present researcher to develop a frame of reference to study the cognitive style of breast cancer patients, to ascertain in what particular way the victims respond to their illness - or reflected in their perceptions and retained in their memory-inputs to influence attitudes and behaviour. What are their perceptions? And their cognitive distortions, if any.
Researchers in the Western Countries observed that the diagnosis of breast cancer can cause feelings of helplessness and loss of control that have been found to be related to anxiety, depression, and poor prognosis among cancer patients (Watson et al, 1991; Stanton and Snider, 1993). Some individuals, however, are able to maintain a sense of well-being in the face of a diagnosis of breast cancer. This well-being seems to be related to a positive sense of control that is based on their reactions to the diagnoses (Burgess et al, 1988) as well as to the differential use of specific coping strategies over time (Cunning Ham et al, 1991; Taylor et al, 1984). Taylor (1983) noted that control was important in adjustment to breast cancer, whether that sense of control came from personal agency or from a belief that one's physicians or treatments could control the disease. In addition, Ell et al (1989) found that personal sense of control was the only psychosocial factor significantly related to adaptation at 6 months follow-up.

It has been argued that the relationship between control and health outcomes may not be a simple linear one: that is, "control is good and the more one has the better". Research suggests that Western psychology's understanding of control as active and instrumental has many culture-bound features and is not always helpful or desirable (Shapiro et al, 1987). This decisive, instrumental mode of control—the so-called fighting spirit attitude referred to in cancer research focusing on control—is typically contrasted with a negative, yielding mode—a timid, passive, helpless resigned and avoidant coping style (Roth and Cohen, 1986; Classen et al, 1996). This bias toward active control is reflected in most psychological control assessment
inventories and coping questionnaires that do not distinguish between what we refer to as positive yielding (acceptance) and negative yielding (resignation or passivity).

The emphasis on gaining active control, particularly in the face of situations and illnesses that may be beyond one's ability to control, can lead to feelings of undue personal responsibility, blame, and guilt (Spiegel, 1991). Furthermore, research also suggests that a greater sense of or belief in one's ability to control and an excessive desire for control may sometimes actually suppress, rather than enhance, immune function and may heighten rather than attenuate cardiovascular reactivity and risk. It appears that locus of control of behaviour of breast cancer patients has not been studied extensively. Therefore, present researcher has become interested to explore this behavioural component in a group of breast cancer patients.

Facing a diagnosis, cancer patients tend to have a poor quality of life as a consequence of numerous concerns about their illness and treatment and about the deficits caused by the malignancy or the treatment. These range from the usual day-to-day activities like eating, chewing and communication to subjective concerns like self-esteem and dependence.

The occurrence of a number of concerns, particularly the severe ones are likely to result in a poor adjustment and quality of life, which may become poorer if these concerns remain unresolved. It is, therefore, important to
understand the coping mechanisms used by the patients to deal with the concerns.

When confronted with the traumatic life events, individuals normally resort to alleviate the resultant stress. In the present investigation, an attempt has been made to identify the different psychogenic implications and coping mechanisms used by the patients suffering from breast cancer.