The postoperative emotional and interpersonal effects of radical mastectomy on patients at Cook County Hospital

Willie Payne Rucker

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THE POSTOPERATIVE EMOTIONAL AND
INTERPERSONAL EFFECTS OF RADICAL MASTECTOMY ON PATIENTS
AT COOK COUNTY HOSPITAL

A THESIS

SUBMITTED TO THE FACULTY OF ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY

WILLIE PAYNE RUCKER

SCHOOL OF SOCIAL WORK
ATLANTA, GEORGIA
MAY 1960
DEDICATION

To my mother, Mrs. Luola C. Rucker,
Mrs. Idele Gray, and "Mac" for your unfaltering
love, support, and your understanding.
ACKNOWLEDGMENTS

To all those persons who have shown immeasurable interest, encouragement and assistance toward making the writing of this thesis possible, the writer wishes to express her gratitude and appreciation to the following persons: Miss Virginia Hannon, thesis advisor; Miss Doris Smith, special Medical Caseworker; Miss Josephine Taylor, Director of Social Service Department, Cook County Hospital, Chicago, Illinois; and faculty and staff of Atlanta University School of Social Work.
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CHAPTER I

INTRODUCTION

Significance of the Study

Cancer is the second leading cause of death in the United States today. Among women, cancer of the breast is the second most common type of cancer, being exceeded in incidence, though not greatly, only by cancer of the female reproductive organs. Breast cancer is rare in men.\(^1\)

The problem of cancer is one of vital concern to every living American. The disease is one which, paradoxically, is so intimate that it consists literally of the individual's own flesh and blood, while at the same time it is alien and so ruthless that if left unchecked it will kill him. Cancer concerns us all because it is capable of affecting everyone of us in one way or another. No age, race, or stratum of society is spared the ravages of its onslaught, and it is assuming larger proportions every day as a public health problem. Thus, two families out of every three of our population will eventually be touched by it and if present trends continue, some twenty-four millions of people now living in the United States will die of it eventually.\(^2\)

The symptoms of breast cancer cannot be easily attributed to other illnesses as can the symptoms of rectal or gastric cancer. Most women in our society are aware that a painless mass in the breast is a pathological sign.


When a woman discovers a mass in her breast, she is likely to recall every unfortunate incident involving breast pathology known to her. As soon as she is aware of the symptoms, a sequence of emotional reactions and reality events begins. The sequence can be characterized as consisting of four stages: onset of symptoms, diagnosis, hospitalization for surgery, and convalescence. Each phase contributes to the patient’s ability to integrate the total experience, and modified by her lifelong adaptation in living, sets the tone of her post-operative reactions.¹

When the symptoms of breast cancer are recognized, the patient immediately begins to anticipate what she believes is going to happen to her during the treatment process. The implications of the suspected disease with resultant surgical treatment serves to mobilize the patient’s anticipatory anxieties and preparatory resources. Often, the symptoms arouses such acute anxiety that the patient delays seeking medical attention. Or, if medical help is sought, a series of defensive maneuvers may be initiated to avoid the inevitable treatment process.

Fortunately, many women are able to seek medical attention and carry through the necessary treatment. This does not mean that these women obtain medical treatment without great emotional cost to themselves. Because of the amount of information which most women have about breast symptoms, the most frequent concern of the patient with a breast mass, is whether or not she has cancer. To most, this concern can be equated with the fatality of the disease. However, other important fears may also be activated when the symptom is first discovered.

Concern about recurrence if the diagnosis should prove to be cancer is often experienced even before treatment is initiated, or concern about mutilation if surgery should prove necessary is expressed. Some women are particularly worried about the effect of the entire experience on their families and home.

On the day that the diagnosis is established and the patient is informed of the necessity for surgery, all of her anticipatory fears are brought clearly into focus and invested with reality. Whether or not the patient is told she has cancer will depend on the interaction between the physician's convictions about imparting information to cancer patients, and the patient's insistence to be told details. In either case, however, the patient's dread begins to mount slowly and progressively.1

The threat of mutilation or removal of a part of the body is a very damaging experience, especially to insecure individuals. A variety of reactions from patients who received recommendation for breast surgery have been noted. The possibility of radical mastectomy could cause these conflicts in a patient.

Surgery whether major or minor, involves a difficult decision for any patient, and the patient's psychological readiness for an operation is as important as an accurate recording of his breathing rate. Such readiness requires the mobilization of the forces within oneself to face a situation that seems to threaten one's life. One patient may be afraid of death, another of crippling or disfigurement, and still another of increased dependency or disability, but for the most patients, these fears intermingled with countless others, will be present to some degree.2

1Ibid.

Removal of a breast is a very great insult to the patient. Since the site of the operation is an influential factor in a patient's reaction to a recommendation of surgery, an appreciation of the meaning of the breasts to women is explored because the breasts are the anticipated area of therapy. Where there is full recognition of this by the surgeon, nurse and social worker, the patient may receive the interpretation and support she needs both before and following operation and be better prepared toward acceptance.

Breasts are among her most prized possessions. They have two psychological meanings. First of all in our culture, breasts have a particular sexual significance. They are glamorized in street car ads and the movies. Women and men have been made more breast conscious. In fact when we examine the situation critically we see that the breasts are the only positive evidence of femaleness. The reproductive organs are internal and the area visible to the public is smooth and concealed. The other major meaning of the breast lies in its function as a milk bearing organ. It is equated with something that is uniquely female, the role of a mother. In our culture, this has become superficially less important, since fewer mothers pride themselves on the ability to breast feed. This is, however emotionally misleading, since there remains an unshakable and universally unconscious symbolic connection between the breast and motherliness. To threaten the breast is to shake the core of her feminine orientation.

Radical mastectomy is an universally accepted treatment of breast cancer and involves the removal of the breast, pectoralis major and minor muscles, and the axillary contents.

---


Radical mastectomy is defined as the amputation of the breast with wide excision of the pectoral muscles and axillary lymph nodes.¹ This operation, although very handicapping emotionally, is one of the least handicapping physically of radical removals. With a skillful operation and painstaking instruction in regaining full arm function, the patient with a favorable prognosis usually is able to return to her former occupation and normal way of life with few modifications: The patient with an unfavorable outlook, although disabled by a slow downhill trend, may be helped also for a time at least to lead a life of usefulness. Much depends upon success in bringing the patient to look upon this event in her life as less disabling than if she had sustained the loss of a more useful limb. The elderly woman beyond child bearing years may appear to accept the fact that the usefulness of her breast is past. The young married woman who wants more children and the single woman hopeful of marriage need medical counsel and should be encouraged and given an opportunity to talk over the question of pregnancy and breast feeding with the physician. The patient who is fearful of losing her husband following such an operation has usually other reasons for insecurity which, if not recognized as a problem and faced, may present a real obstacle to her recovery.²


For everyone, cancer presents a health problem of serious magnitude. For social workers, cancer has a special significance as an economic, emotional, educational, social as well as medical problem with far reaching ramifications.¹

Economically, the high cost of prolonged medical care today places an excessive financial responsibility on the family with an average income. Cancer in this respect takes its toll. Also, it can impose an extended absence from or, all too often, loss of the job. Further, cancer generally leaves the patient in a physical condition which requires financial investment in a rehabilitation program to retrain for another type of gainful employment. In order to meet these economic needs of the cancer patient, it is essential for the social worker to determine and make maximum use of all community resources available. The emotional problems of patients with cancer require skillful exploration. Anxiety often prevails with the patient, and some patients develop a guilt reaction, convincing themselves that this dreaded disease has been inflicted upon them as punishment. Hostility is aroused in other patients who resist the dependence on family and community which the illness from cancer imposes. By recognition of these emotional attitudes affecting the patient, the medical social worker as a member of the medical care team is better able to assist the patient in management so that she can get the maximum benefit from treatment.

¹Ibid., p. 12.
Socially, family relationships often become impaired when cancer strikes one of its members. There may be the attempt to over-protect the patient or the tendency to separate her from former responsibilities. There may be other social problems in the patient's home and community life which prevent her from seeking diagnosis, and accepting or continuing with treatment. In turn, these problems can influence the patient's course of illness. In the relationship developed with cancer patients the medical social worker detects these various social factors and helps the patient to alleviate or adjust to them constructively.¹

Purpose of the Study

The purposes of this study were: to determine how radical mastectomy patients adjusted to traumatic and stressful situations before the operation; to determine how they adjusted emotionally to their physical condition following surgery; to learn the social, economic and emotional problems encountered or anticipated upon return to their respective communities; and to determine the role of the social worker regarding servicing these patients.

Method of Procedure

The selection of patients for this study included those patients who were hospitalized on the Female Surgical ward and those who were subsequently admitted and had had radical mastectomy prior to and through January 1960.

The cases studied were selected from those falling into this category during the first four months of the writer's six months stay in the hospital. Out of the average ten patients per week who underwent radical mastectomy at Cook County Hospital, twenty-five were selected in chronological order.

Interviews with the patients after radical mastectomy were conducted by the writer to obtain material for this study. A review of literature in relation to the subject was used for background information. Medical case records were used to gain the necessary medical-social history. The social service face sheet information revealed the patients identifying data, family composition et cetera.

Scope and Limitations

This study was limited to patients hospitalized and treated by the breast tumor clinic of the Cook County Hospital, Chicago, Illinois who had undergone radical mastectomy prior to February 1960.

Since this study is concerned with the Post-operative and Interpersonal Effect of Radical Mastectomy on Patients at Cook County Hospital, a description will be given of the present services provided by the hospital.

It is recognized that there are limitations, as there was not as much time to devote to the follow-up of each patient as anticipated, and in the interview with the patients there were certain areas in which they were unable to give the requested information. The findings will be presented under headings including personal, family, work and community adjustment. The emotional, spiritual and social needs will also be considered.
CHAPTER II

SOCIAL SERVICE AT COOK COUNTY HOSPITAL

Setting of the Study

Cook County Hospital is the largest general institution of its kind in the world. It covers over eighteen acres in the Medical Center, and twenty-one buildings. Three thousand five hundred full-time employees are required to keep the hospital functioning. At present, the hospital has more than 3,470 beds, 3,300 of these being in the General Hospital and 174 in Mental Health. The General Hospital includes Contagious, Chest, Men's Medical and Children's Hospital in addition to the main Building.¹

Cook County Hospital provides medical care on an in-patient and out-patient basis for residents of Cook County who are unable to pay for private medical care. A great deal of research and pioneer work in medicine has always been done in the hospital. The first blood bank in America was started by Dr. Bernard Fantus in 1937 at Cook County Hospital. Now, there are also Bone, Eye, and Artery Banks there. Fourteen years ago, the Hektoen Institute for Medical Research was started to serve as the research facility for the hospital. This is a private, non-profit organization which collaborates with the hospital to utilize the vast clinical material available there. All medical schools in Chicago are represented on the staff of the Hektoen Institute. Eligibility for treatment was determined by the Cook County Department of Welfare, Institutional Service Division, which had a department

¹Josephine Taylor, "General Historical Statements," (Chicago, Illinois, Cook County Hospital, 1955).
located in the hospital. An over-all flat rate of $18.48 daily was charged for all services. This fee was obtained from either the patient himself, his family, insurance plan, the Township Relief Supervisor, the Cook County Department of Welfare or the State of Illinois through its program of Assistance to the Medically Indigent Patient. In cases where payment seemed unobtainable from any of these sources, the county absorbed the cost.\footnote{Annual Message of Daniel Ryan, President of Board of Commissioners, Cook County, Illinois, (Chicago, 1957), p. 113-117}

Development of Social Service

Social Service at Cook County Hospital was first considered in 1910 when Mr. Sherman Kingsley of the United Charities sent one of his workers to the hospital to render service to the clients of that organization who were receiving care at the hospital.

In 1911, Miss Marion Prentiss, a graduate of the Illinois Training School for Nurses, and then a nurse on the Obstetrical Service, pointed out the serious social situation of the unmarried mothers. As a result, the School of Nursing decided something must be done. After consideration by the board and further study by Miss Prentiss, it was decided to appoint a person to consider these social needs and take some action about them. Miss Prentiss was appointed as the first social worker and she, subsequently, developed the interest and support of many groups.

In 1918 demands for social workers in the other services of the hospital brought about an increase in the Social Service staff. The staff continued to grow and expand its function.
In 1927 when the Illinois Training School for Nurses discontinued its school and transferred all of its effects to the University of Chicago, the new Cook County School of Nursing took over the plan and policies of the old school. In 1932, during the financial crisis in the county, the Nursing School voted to discontinue the Social Service Department. The attending physicians and interested persons in the community protested, and it was voted that these services be continued.

In October, 1934, Miss Helen Beckley, the Executive Secretary of the American Association of Medical Social Workers, became the second director. She reorganized the department, stressing more complete coverage of all sections of the hospital and less emphasis on obstetrics alone. She was instrumental in planning a field work unit for the University of Chicago and a program to provide summer substitutes to replace regular social workers on vacations. The training program, in recent years has included students from the Atlanta University and Loyola University Schools of Social Work.

Miss Beckley remained Director of the Department until December, 1938. She was succeeded by the present Director, Miss Josephine Taylor, who was the department's first Supervisor appointed by Miss Beckley.

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1Josephine Taylor, op. cit.

2Ibid.

3Ibid., p. 2.
Functions of Social Service Department

The Social Service Department has two sections: the General Hospital and Clinic Section, and the Mental Health Section. There are forty-six Social Workers, one Director and two Assistant Directors for the General Hospital, and one Assistant Director for the Mental Health Section. The General Hospital Section is organized into five services which correspond to the principal divisions of the hospital: namely, Clinics, Medicine, Obstetrics, Pediatrics and Surgery.

"The function of the Medical Social Service Section is to help the patient and his family solve some of the social and emotional problems which interfere with his recovery or his adjustment to disability."\(^1\)

The Department participates in the teaching of students of social work, student and post-graduate nurses, chaplain interns and interns and resident medical students.

Since the early days of the Social Service Department, volunteers have been used to supplement the work of the social workers and provide "extra" services which the caseworker sees as being important for her various patients.

Breast Tumor Services

The special Breast Tumor Clinic Social Worker began work in June, 1949.

The function of this worker is to provide a wider coverage of patients and a more complete and intensive service to patients who are seen in this Clinic.

\(^1\)Ibid., p. 3.
This special Social Worker is paid by the Illinois Division of the American Cancer Society from a grant appropriated on a yearly basis.

The scope of the work of the Social Worker in the Breast Tumor Clinic is threefold in purpose:

1. To assist patients, whether with diagnosis of benign or malignant tumors, to accept and follow medical recommendations, including surgery, clinic care, special hormone therapy, and x-ray therapy.

2. To alleviate, through inter-agency cooperation, those material problems, as financial difficulty or family responsibilities, which might deter patients in the following of the medical recommendations.

3. To plan with the patient and her family for the acceptance of terminal care, utilizing such facilities as nursing homes through the Old Age Pension program, the Chicago Welfare Department Convalescent Home, Oak Forest, private nursing homes, and care in the patient's own home.²

It is the policy of the Social Worker to interview each new patient in the Breast Tumor Clinic, each patient for whom hospitalization is recommended, and those who are referred for x-ray therapy. This has been done in order to determine the feelings of the patients regarding the new clinic experience, as well as to investigate any social factors which might hinder their acceptance of medical treatment.

During these interviews, patients frequently bring out their fears concerning their physical condition and show their response to thought of surgery, if this has been recommended. If the patient does not

²Betty Groh and Oudia Tate, "Report to Executive Board of the Illinois Division American Cancer Society," (Cook County Hospital, Chicago, Illinois, July 10, 1951).
reach some decision. It has been found that the patients, in almost all instances, are not only willing to come to the Social Service Department to discuss their problem, but welcome an opportunity to talk through the situation with an objective person. These interviews have brought forth the emotional reactions of women facing the thought of having to have a breast amputated, thus alleviating some of their anxieties and fears.
CHAPTER III

PRE-ILLNESS IDENTIFYING DATA

Basic to social work service is the concept that each person is unique, different from every other human being. At the same time that each person is different, however, he has certain things in common with the rest of his fellow men. He has certain basic needs and fundamental impulses, sometimes referred to as innate drives.

The questions posed in the writer's mind were: what basic factors other than diagnosis were common with the patients; was the postoperative adjustment unique to specific personalities or similar to all radical mastectomy patients; to what extent did the family affect the adjustment; to what extent was the pre-operative employability of the patient affected by the operation, and what type and degree of community participation did the patients enjoy following surgery.

An analysis was made of the community adjustment, family adjustment, personal adjustment and work adjustment of twenty-five patients following radical mastectomy to determine how the patients' postoperative adjustment compared to their pre-illness adjustment.

Age of Patients before Radical Mastectomy

The patients ages ranged from thirty-two to seventy-five years at the time radical mastectomy was performed. The greatest frequency of patients (eight) was between the ages of forty and forty-five years, while the next largest group (five) fell in the age range of thirty-two through thirty-seven.

Four patients were between the ages of sixty—and seventy, three were in the forty-six to fifty bracket. Two patients each were in the fifty-one to fifty-five and fifty-six to sixty group. The oldest age group, seventy-one through seventy-five included only two patients.

Records show that younger women fall victim of cancer more often than older women. About seventeen percent of all women's deaths are attributable to cancer. Every year cancer takes more women between the ages of thirty-five and forty-four than any other disease.¹

In this study the writer's findings indicate more women between the ages of thirty and fifty are victims of breast cancer than any other age group.

Amount of Education Before Radical Mastectomy

The greatest number of patients, fifteen attended grade school but had less than an eighth grade education. Three patients finished high school and one attended three years. Two patients completed college and one of the patients did graduate study in law. Education has no significance regarding diagnosis of cancer of the breast. This study revealed patients with graduate work are victims of this ailment as well as patients with little or no education.

Marital Status

Of the twenty-five patients in this study who underwent radical mastectomy, five were single, six married, two divorced, six separated and six widowed. The largest group of patients were or had been married.

The separation of one patient occurred between preliminary treatment and her return to the hospital for radical mastectomy. Three patients were estranged several years prior to the onset of the illness. Two patients were separated from their spouses at an interval between radical mastectomy and return to the hospital because of a wide spread of carcinoma. Marital status of patients in this study had no remarkable significance to cancer of the breast; even though the greatest frequency of patients fell in the age group of thirty-five to fifty years, it is believed by the writer it is because most women in this age group are, or have been married.

**TABLE I**

**OCCUPATION OF PATIENTS BEFORE RADICAL MASTECTOMY**

<table>
<thead>
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<th>Occupation</th>
<th>Number</th>
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<tr>
<td>Clerical</td>
<td>7</td>
</tr>
<tr>
<td>Domestic</td>
<td>12</td>
</tr>
<tr>
<td>Labor (skilled)</td>
<td>2</td>
</tr>
<tr>
<td>Professional</td>
<td>1</td>
</tr>
<tr>
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Table I illustrates the occupation of the patients prior to the onset of illness. The greatest frequency of patients was in the domestic group. The occupations engaged in this category were cooks, maids and nurse maids. The next largest frequency was in the clerical capacity. Two patients worked in the skilled labor group which included lathe operator and machinist. One patient who had attended law school one year, "assisted a lawyer friend before my illness." Three patients disclaimed any previous employment. It is doubtful because of the poor prognosis, that
many of the twenty-five patients in this study will be able to return to their previous employment. Most of the work is strenuous, requiring full use of the arms and body. The patients in the Clerical and Professional class, could possibly return to their former employment, but for most of the patients in this group prognosis was very poor and they were unable to take care of their own personal needs.

Symptoms of and Reaction to Radical Mastectomy

The first symptom of breast cancer in seventeen of the cases studied occurred several months to several years before radical mastectomy. The other eight patients experienced symptoms from one to three months prior to the removal of the breast. The following selected cases give examples of onset of and reaction to illness.

CASE A

In December 1957, the patient noticed a lump in her right breast. She was five months pregnant and at first believed the lump to be a formation of milk. The patient stated she began to have severe pain in the right arm pit and was unable to lift her arm above her head. When she returned to the Infant Welfare Station for a pre-natal check-up, she discussed the lump with her Doctor. He suggested she attend a breast tumor clinic. After several examinations and biopsy, she was diagnosed as having cancer of the breast. Patient advised she became so depressed she almost lost her baby. Radical mastectomy was performed in January 1958.

CASE B

In 1950, the patient developed a number of complaints; high blood pressure, "dizzy night sweats," nervousness and persistent indigestion. The patient stated these complaints continued and grew worse until she was taken to a hospital for emergency treatment. After an intensive examination, her case was diagnosed as cancer of the breast. She attended a Breast Tumor Clinic continuously where she received
x-ray and radium treatment. She could not accept the fact that she had cancer and became defiant and indulged in self pity. However, in May, 1958 radical mastectomy was performed.

**CASE C**

The thirty-four year old patient first noticed a lump or thickening in her right breast in 1954. Patient was not concerned about the lump until it began to hurt and she was unable to use her arm. She attended the Breast Clinic in 1957 and soon afterwards had radical mastectomy. Several months later patient had an oophorectomy and on January 13, 1960 hysterectomy was performed.

Number of Children Per Patient Before Radical Mastectomy

Table II illustrates the total number of children, per patient, before radical mastectomy. Two patients gave birth to children after surgery was performed. Of the twenty-five patients studied, nineteen had from one to fifteen children. Even though many studies have indicated there is no correlation between child-bearing and cancer of the breast, four-fifth of patients in this study have given birth to children and all excepting five stated they breast fed their children.
TABLE 2

NUMBER OF CHILDREN PER PATIENT

<table>
<thead>
<tr>
<th>Number of Children</th>
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Ethnic Group

The twenty-five cases of radical mastectomy which were studied involve two ethnic groups, Negro and White. Twenty-one of these patients were Negroes and four were white. There is no predictable correlation between cancer of the breast and ethnic groups. The explanation for the larger per cent of Negroes than white in this study lies in the fact that the Cook County Hospital, where study was made, services more Negroes than white. Seventy-five per cent of patients at Cook County Hospital are Negroes.

According to identifying information, most of the patients in this study were or had been married. The greatest frequency of ages was between forty and forty-five. Most patients had attended grade school but had less than an eighth grade education, and they were in the unskilled or domestic labor class. The patients onset of cancer of the breast had a duration of from one to eight years. All but six of the patients studied had from one to fifteen children.
CHAPTER IV

PREOPERATIVE AND POSTOPERATIVE ADJUSTMENTS

The foregoing chapters have given a description of Cook County Hospital, Chicago, Illinois, the community in which this study was made; explained the nature of cancer and radical mastectomy; and pointed out the pre-illness identifying data. This chapter will be devoted to a consideration of the findings in twenty-five cases studied.

Emotional Needs

One of the main functions of the medical social caseworker is to help the patient and the relatives of radical mastectomy patients use their personality reserves so that the patients may not go through life burdened additionally with a neurotic emotional personality difficulty that the surgery crystallized. It does not matter how beautifully a radical mastectomy is performed, how well a patient is restored to health, if the individual is not able to develop the courage to face reality, to fight the battle of life and to live a creative type of existence. It is not possible to meet the needs of the total patient if the important area of his emotional development is overlooked.

How a given individual reacts to a permanent physical impairment may change his plans for the future, modify the appearance of his body, require his having long or painful treatment or restrict some of his activities - all of which are directly related to his life experiences. The time of life at which the impairment occurs is also of great importance. If radical mastectomy is performed late in life, the patient does not likely experience the sudden shock of loss of function or
alteration of function as would a younger woman who anticipates motherhood.

Frances Upham has said that most patients ordinarily can meet the threat of illness and handicap, provided they have the sympathetic support of their families. She further states that healthy family relationships are basic to sound emotional development, which in itself furnishes a strong safeguard against proclivity of illness. If family understanding of the patient and her illness is lacking or if there is a basic deficiency in the patient-family relationship, recommendations made regarding treatment and improvement create additional problems. If the family of a patient is sympathetic, understanding and sincere, patients are known to respond to treatment more readily than patients without this type of relationship with their families. Seven patients in this study, with unsalubrious family relationship, felt rejected, despondent and unwanted. These patients responded poorly to treatment and most had no desire to live.

Postoperatively these patients continued to feel rejected and unloved despite the daily visits and interviews from the special case-worker.

For example:

Patient L

Patient L, a forty-five year old woman, had been estranged from her family for ten years. Patient had two brothers and a sister in the city, but the exact whereabouts were unknown. Both parents were deceased. Patient was not of the aggressive type and her friends were few. She said she had not had a visitor during her entire stay in the Hospital. She expressed a desire to die.

Patient M

Patient M, a forty-eight year old mother of fourteen children, had been divorced for ten years. Her spouse was granted custody of the children. Patient had four siblings; however, only one sister and one of her children visited infrequently. Patient stated on several occasions that she would rather be dead than to be unwanted and continue to suffer.

Ten patients, prior to illness, had positive sympathetic support of their families. Their healthy relationships contributed to the emotional adjustment to the operation.

Two examples:

Patient N

This patient had been hospitalized to months. Her husband, five children and three siblings visited every visiting day. They brought small tokens - sometimes a newspaper or magazine, assuring patient of their love and understanding. This family were recipients of welfare as the husband had a heart condition and was no longer employable. However, because of the closeness and understanding of patient's illness, on part of her family she was emotionally secure, and making an excellent adjustment to her illness.

Patient O

Patient O's only living relative was her spouse. He visited twice a day on visiting days, walking about twenty blocks each day. He was retired, receiving a small monthly pension. Patient was also an ardent church member. Her room was filled with cards and flowers from her friends. Patient was so emotionally secure, even though her prognosis was poor that she often spoke of returning to her home and her church activities.

Eight patients seemed to have not been dependent on their relationship with their families. Their attitudes did not indicate one way or the other if they cared whether their families or friends would visit. Post-operatively there was no significant change in the attitudes of these patients.
Spiritual Needs

Every individual has spiritual needs which are distinct from, although closely interrelated with, his other needs. The necessity of meeting one's spiritual needs in order to insure full growth physical, mental and emotional, is almost universally recognized.

Religion is of supreme importance in the development of an individual.

Reverend John A. O’Brien says:

The home is the first and most important school. Like soft wax, the mind of the child receives impressions with ease. It is the first impressions which sink the deepest and remain the longest. Impressions received during early childhood and in the preadolescent stage set up mental patterns and codes of conduct in the light of which all the experiences of later life are interpreted and evaluated.¹

All of the patients included in the study had some religious affiliation except three. Sixteen were Protestants and six Catholics.

The Catholic Church makes attending mass obligatory on Sundays and holidays.² The six Catholic patients attended mass every Sunday before hospitalization. Although attendance at Sunday service is not obligatory for many Protestants, ten Protestant patients attended services every Sunday during the month before hospitalization; six did not.

Of the six Catholics and ten Protestants who attended services regularly, their religion was meaningful and played a big part

in the acceptance of their illness. The Catholic patients were visited regularly by the Priest and given Holy Communion. A religious atmosphere in their room was created by displaying a picture or sacred statue, an effigy of some favorite Saint to whom she might turn in times of trouble. These symbols helped to make the abstract concrete. The ten Protestants were provided with religious literature by the hospital Chaplain. Several of their ministers visited frequently offering prayer and communion once per month. These patients, unlike the patients without a religious affiliation, were more accepting of their illness. As Leonard Mayo has said, "in the final analysis, peace of mind and soul, and a faith in a Supreme Being are the bases on which lasting security is built. Peace of mind and soul and a strong faith can be achieved only through religion."

Not all of the patients participated in the activities of their church. However, five of the Protestants participated in the activities of their church. Two were choir members, one a Sunday School Teacher and two belonged to clubs affiliated with the church.

The patients who participated in activities of their church stated they would return to their former role in the church when they are physically able to do so. The patients who attended church but were not active stated they would continue to attend regularly. One of the patients who had no religious affiliation said she planned to attend

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church upon return to her home and community. The postoperative religious adjustment is not conclusive due to the fact many of the patients were still hospitalized at time this study was completed.

**Physical Needs**

Ordinarily, the social worker considers the physical needs of individuals to refer to such basic human requirements as food, clothing and shelter. In this study, however, the term "physical" is given a special connotation and embraces such factors relating to the disease entity as diagnosis, treatment and rehabilitation. Because all of these needs are so interrelated, they necessarily fall into more than one category.

Vital factors to be considered in the physical needs of patients with breast cancer were the doctor's seeing the patient early in the course of the disease, recognizing it, and instituting therapy. Unfortunately, however, the onset and chronicity of this disease is such that diagnosis is sometimes delayed. The patient and even the family physician may suppose that the condition is a benign tumor rather than malignant. Resistance to diagnosis and treatment is one of the difficult problems with which doctors, nurses and social workers must deal. Some patients do not want to go to the hospital or clinic.

In none of the cases could the approximate time for the onset of the disease be elicited. This was due to the fact that most patients said they paid little attention to the early symptoms. The latest diagnosis made was one month prior to the end of the study and one case had been known to the Breast Tumor Clinic since 1950.
Many of the patients in this study preoperatively were not able to pay for their medical care and hospitalization. Some were emotionally disturbed and unable to face reality. The special caseworkers, assigned to the Breast Tumor Clinic gave psychological support during period of diagnosis and treatment as well as interpreted and informed patients of other resource agencies where financial or medical assistance could be obtained. Postoperatively the caseworker continued to offer support as long as the patients were hospitalized and often after they had returned to the community.

Reaction To Diagnosis

The diagnosis of cancer frequently leaves the patient confused, bewildered and apprehensive. He is faced by the necessity of deciding what to do about it. Often he is afraid to have the operation and afraid to risk not having it. Frequently the caseworker is asked to help the patient reach a solution for some of the problems associated with admission to the hospital. Patients exhibit a variety of reactions to the initial diagnosis and recommendation of breast surgery, which in turn places a variety of demands on the therapist and social worker having contact with them.

Although many patients are not told their diagnosis, the recommendation for surgery makes them suspect malignancy. The indefiniteness of the word tumor and the uncertainty about what is to be done with them combine to produce a state of apprehension.¹

Fear of the knife is often expressed, and is frequently felt but not articulated. The threat of mutilation or removal of a part of the body is a very damaging experience, especially to insecure individuals. Such feelings are particularly keen when a genital organ is involved.\(^1\)

Of this group of twenty-five patients studied, seventeen were receptive and cooperative in relation to the diagnosis and recommendation of breast surgery, seven were reluctant or hesitant and one patient returned after several months for treatment and radical mastectomy.

The type of reactions manifested by the women classified in this study to the recommended procedure and hospitalization, is found in the following illustrations:

Case P

This patient gave no verbal or visible emotional indication of anxiety or hesitancy in making a plan for hospitalization and radical mastectomy. She further indicated her willingness by asking if she might "get it over immediately."

Case Q

This patient articulated no fear of surgery, but voiced an inability to make plans for admission until a later date, which she indicated would be about four weeks. Her stated reason for the delay was that she was supervising her employed sister's minor children.

Case R

Patient was at first resentful and hostile when informed of her diagnosis. She used her illness to get attention and she was not in agreement with the recommendation for radical mastectomy. However,\(^1\)

\(^1\)Ibid., p. 3.
after persuasion and encouragement from her family, patient consented to hospitalization and radical mastectomy.

This study reveals the majority of the patients were cooperative in relation to accepting the diagnosis and recommendation for breast surgery. This was attributed to the fact that these patients were married or had been, had children, and the removal of the breast was not as threatening as it would have been to a single or younger woman who anticipated having children. The seven patients who were not accepting of the recommendation for breast surgery needed and received support from the caseworker before and after surgery.

Personal Adjustment

Under personal adjustment, the writer considered the following eight factors preoperatively and postoperatively: general appearance, amount of activity, alcoholism, initiative, sociability, talkativeness, mood and irritability.
### TABLE III

**PREOPERATIVE AND POSTOPERATIVE PERSONAL ADJUSTMENT**

<table>
<thead>
<tr>
<th>Personality Factors</th>
<th>Preoperative</th>
<th>Postoperative</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>15</td>
<td>12</td>
<td>25</td>
</tr>
<tr>
<td>Abnormal</td>
<td>10</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>10</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td>Abnormal</td>
<td>13</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Excessive</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Alcoholism</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>23</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>Abnormal</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Initiative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>14</td>
<td>9</td>
<td>25</td>
</tr>
<tr>
<td>Abnormal</td>
<td>11</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Sociability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>13</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>Abnormal</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Lacking</td>
<td>8</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Talkativeness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>12</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>Under</td>
<td>8</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Over</td>
<td>5</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Mood</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>13</td>
<td>14</td>
<td>25</td>
</tr>
<tr>
<td>Elated</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Depressed</td>
<td>4</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Apathetic</td>
<td>8</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Irritability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>7</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>Abnormal</td>
<td>18</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

There were seven patients prior to their illness, who exhibited irritation appropriate to situations and annoyance disproportionate to the stimulus on situation presented. Postoperatively the normal
frequency category increased to fifteen patients and the abnormal decreased to ten patients. This reaction was probably due to the physical and emotional strain of the operation on patients. It is also to be considered the poor prognosis of many of the patients could have been a contributing factor to this reaction.

There were fifteen patients prior to the operation who advised they were considered clean, tidy and neat. Postoperatively, this group decreased to twelve, with some patients who no longer felt as much like dressing as carefully as before. Ten patients were described in previous records as careless or below average dressers preoperatively. They continued to exhibit the same disinterest in their appearance following radical mastectomy as well as three other patients. The operation affected the attitudes of only three patients as far as appearance is concerned.

Ten patients, prior to the onset of their illness, had outside interests and engaged normally in activities with groups. Two patients were considered to have found most of their interests away from home and were constantly active, according to the patients. Thirteen patients had introverted qualities; for example:

Case S

Patient S had been a withdrawn, depressed person since childhood. Both parents of patient died while she was an infant. She want to reside with a maternal uncle and aunt who had several children of their own, and they were tenants on a farm. Because of the low income of this family, patient said she never received a birthday or Christmas gift. She received little or no affection and love. Patient was not socially aggressive and spent most of her time alone and engaged in limited activities. Her Postoperative adjustment tended toward deficient activities.
Upon return to their homes following radical mastectomy, patients were advised to participate in non-strenuous activities. Those patients who displayed considerable interest in groups and participated freely in activities were rated in the normal activity group. Preoperatively, there were ten patients considered to have engaged normally in activities. The number of patients rated postoperatively as deficient in activity is expected to increase as several of the patients who remained in the hospital at time study ended, and were considered normal in their preoperative activities, said they no longer had a desire to participate in the activities they did before entering the hospital. It is believed the six remaining patients will continue to enjoy outside activities as before, as they have made an excellent adjustment in the hospital and seem to enjoy being active.

It is believed the increase from thirteen to seventeen patients who went from a normal amount of participation in activities to an abnormal amount was due to the fact that several of the operations were recent and patients had not had a chance to make an emotional adjustment. In addition the prognosis was poor with several patients, making it realistically difficult to participate in activities, over and above any emotional factors which may have been present.

Prior to illness, twenty-three patients either drank moderately or were teetotalers. Two patient were known to drink excessively. After the operation, most of the patients advised they were complete abstainers. Only one patient continued to drink excessively.
This patient's siblings, with whom she resided, were known to be inclined to drink excessively. This led to patient's drinking for several years. Family Court awarded her husband full custody of her children because of her drinking. Following radical mastectomy, patient continued to drink. This made healing of her incision difficult.

The study reveals the patients had a tendency to drink less or had no desire to drink at all postoperatively.

Fourteen patients exhibited a normal amount of initiative prior to illness. They assumed responsibility for jobs and upkeep of their families. Eleven patients were lacking in initiative toward employment, family or self-betterment. Following radical mastectomy, the patients in the normal category decreased from fourteen to nine. As many of the patients' physical condition will not allow them to return to the type of work they were engaged in preoperatively, the initiative postoperatively would necessarily show a considerable reduction.

Prior to illness, the case records indicate twelve patients were considered to be normal conversationalists. Eight patients were considered to be undertalkative. These patients tended to be seclusive, withdrawn individuals who said they preferred individual sports, and were lacking in sociability. There were five patients who were overtalkative. The latter two groups of these patients were considered to be inadequate personalities. They were maladjusted in the early home situations in which there were elements of rejection and sibling rivalry. Several of the patients were from large families where sibling rivalry was inevitable. Two patients stated they had step-mother's and step-brother's and sister's and they often felt rejected. These patients tended to overcompensate by becoming individualistic and outspoken. Following
radical mastectomy, five out of twelve patients remained normal conversationalists, and eight patients instead of five postoperative were overtalkative while twelve postoperative patients were undertalkative. Since mood is so closely related to sociability and talkativeness, this study revealed the majority of the patients were of consistent mood and temperament. There were eight patients who consistently showed an absence of abnormal mood changes prior to the onset of the illness. Six patients showed depression (affect) frequency, postoperatively.

This study reveals more patients had a tendency to be withdrawn and uncommunicative postoperatively than before surgery. The reason for the large decrease in the inter-personal relationships and activities of patients was attributed to the physical and emotional effect of the operation on patients.

Prior to radical mastectomy there were thirteen patients who responded in a normal socially acceptable manner. Four patients were embarrassingly frank. These patients were considered abnormal. Postoperatively, ten patients were considered normal in their degree of outspokenness while one was considered abnormal. Eight patients who were lacking in sociability increased to fourteen postoperatively.

Family Adjustment

When a patient had had radical mastectomy and was ready to return to her home, families revealed various attitudes and feelings. Several patients were able to return to the same situation in which they were prior to their illness. Prior to hospitalization and radical mastectomy,
six patients resided with their spouses, three with parents, seven with children and five with siblings. Four lived alone. After mastectomy five patients stated they would continue to reside with their spouses, four with parents, six with children, six with siblings, two went to a nursing home and two continued to live alone. There was no marked shift in the living arrangement of the patients postoperatively.

In tabulating family adjustment, the writer considered the patients' attitudes toward the family members and their attitudes toward them; what family members tended to reject them and vice versa; and to what degree the family tolerated, accepted, or rejected the patients. Twelve patients were rated as having a good family adjustment prior to illness, being friendly, cooperative and accepting their share of the responsibility. Postoperatively, this group decreased to eight patients. The families of these eight patients accepted the patients as they were and made the most of their adjustment.

The thirteen patients whose relationship with their families were poor made poor adjustments to their illness. Postoperatively these patients continued the same patterns.

The feelings and behavior described in patients in their families which Ruth D. Abrams refers to above was seen in the twenty-five patients included in this study.

The following case gives an example of pre-illness and postoperative adjustment:
Case T

Patient T had a close-knit family relationship before radical mastectomy. Every decision concerning the family was left to the discretion of patient. Following radical mastectomy, her family, being overprotective of patient, did not consider or ask for her opinion on family matters. Patient, seeing this as a form of rejection, regressed and was readmitted to the hospital.

The attitudes and reactions of the patient and her family depend upon her chronological age, emotional maturity, her general patterns of behavior, her typical reactions to stress and crisis, her family constellation and relationships, her economic situation and activities as a member of society. Interwoven into this composite pattern is her knowledge of cancer in general and of her own illness and its probable outcome.¹ The attitudes and reactions of the family will also be determined by feelings about the specific member who has cancer.

Work Adjustment

The work adjustment of the twenty-five patients studied was rated in four categories: good, fair, poor and none. A good work adjustment rating was given to patients who were employed full time and productively, earning a regular salary. A fair rating indicated that the patient worked regularly but productivity was not up to expectation or that performance was only satisfactory. A poor work adjustment indicated that the patient had irregular employment or was totally inadequate in his work activity.

TABLE 4

PREOPERATIVE AND POSTOPERATIVE WORK ADJUSTMENT

<table>
<thead>
<tr>
<th>Type of Work Adjustment</th>
<th>Preoperative</th>
<th>Postoperative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total 25</td>
<td>25</td>
</tr>
<tr>
<td>Fair</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Good</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Poor</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>None</td>
<td>2</td>
<td>18</td>
</tr>
</tbody>
</table>

Prior to illness, twelve patients had good ratings. Postoperatively only five had good ratings. These patients returned to jobs they held prior to radical mastectomy. Two other patients in this study who returned to work after surgery made a poor work adjustment. Some did not plan to work at all postoperatively. The employment rate was exceptionally low because of the recency of most of the operations. This meant that some patients had not had time to convalesce, therefore, it is possible that the number of patients who will eventually be employed might become higher, so no real conclusions can be drawn in regard to the future adjustment.

Community Adjustment

In evaluating the community adjustment of these twenty-five radical mastectomy patients, the main consideration was given to whether the patient would be able to return to community affairs, through participation and association with friends, religious and recreational group activities. This study revealed that, prior to the operation, fifteen patients participated in a few groups; two patients participated in many groups and five patients showed no participation at all. Three patient's group participation was
unknown. Postoperatively, eighteen patients showed no participation and six patients had a few group participations. There was one patient in the "many" category postoperatively. These findings were obtained from patients who had had radical mastectomy, were discharged to their communities for a while and had returned to hospital or clinic for further treatment.

Table 5 shows the preoperative and postoperative community adjustment.

### TABLE 5

**PREOPERATIVE AND POSTOPERATIVE COMMUNITY ADJUSTMENT**

<table>
<thead>
<tr>
<th>Participation</th>
<th>Preoperative</th>
<th>Postoperative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Many</td>
</tr>
<tr>
<td>Associates</td>
<td>25</td>
<td>5</td>
</tr>
<tr>
<td>Groups</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Hobbies and Recreation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reading</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Radio</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Movie</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Television</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>Sports</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Religious Activities</td>
<td>5</td>
<td>17</td>
</tr>
</tbody>
</table>

There was a noticeable change in the community adjustment of patients. Postoperatively, seventeen patients who were associated with groups prior to the operation dropped to seven; hobbies and recreation of solitary
diversion increased as there was more time devoted to radio, television, reading and movie going than before. There was a slight decrease in the religious activities, of the twenty-two patients who attended church regularly before radical mastectomy, only twenty patients attended, or planned to attend postoperatively. Sporting activities also showed a decrease.
CHAPTER V
SUMMARY AND CONCLUSIONS

The foregoing study of the Emotional and Interpersonal Effect of Radical Mastectomy on patients at Cook County Hospital, has revealed many findings. Complete answers, however, cannot be given instances, such as the preoperative adjustment, emotional and spiritual information was furnished by the patient and may not be as accurate as if obtained from other sources.

The study was carried out with the use of a schedule which gave consideration to identifying data and pre-operative and postoperative social adjustment. The sample was limited to twenty-five patients who had had radical mastectomy at Cook County Hospital who were hospitalized during the writer's block field work placement between September 1, 1959 and February 29, 1960.

Because of the emotional effect of radical mastectomy on patients observed by the writer during her advanced field work placement, it became the writer's intention to learn something of the components of these reactions and the relatedness between the initial reaction to diagnosis and the acceptance of the recommended therapy.

Various factors investigated in this study led the writer to draw some conclusions as to their significance, although the limited number of subjects preclude any consideration of general trends. However, on the basis of the findings, certain things seemed significant enough to stimulate interest in future study on the subject.

Findings include the following: the average patient's age was forty
to forty-five years, and the majority were or had been married women whose illness had a duration of several months to nine years prior to this study. Following radical mastectomy there was considerable change in the behavior of patients. About two-thirds of the patients were deficient in activity postoperatively compared to two-fifths of the patients who had normal activity preoperatively. Patients who were sociable decreased after the operation from thirteen to ten patients. Personal adjustments were affected. Appearance was the least affected by the operation, whereas, such characteristics as initiative, irritability, talkativeness and sociability were most affected. Activities of patients decreased considerably following the operation. There was decrease in the employment, religious activities increased and community adjustment was less good of the patients studied.

With regard to family acceptance, parents assumed greater responsibility than children, siblings or spouses. Those patients who had young children displayed concern for their welfare. With families who showed more acceptance and permissiveness, patients showed better adjustment.

Primarily, the meaning of surgery of the breast was considered significant in the approach to the study. It was considered a crisis situation and reactions of conflict in facing it were considered normal. The more specific reasons for the various emotional reactions exhibited were explored from a general frame of reference. The breasts, being a sexual symbol, seemed a contributing factor to patient's reaction and emotional disturbance.

In regard to the factors contributing to the reactions to the illness, it was found that the largest number of patients who were accepting
of their condition and the least disturbed, were married with children. These findings were in keeping with the theory that the fulfillment of the feminine role through marriage and motherhood reduces the significance of the breasts' symbolic meaning.

The role of the social worker in working with patients recommended for breast surgery was analyzing the situation, the patient and her abilities, interpreting the setting, the physical condition and therapy in terms of patient's understanding; advising the patient in relation to her needs and employing and directing the patients to supplementary resources as the need arose. The social worker needed to acquire additional knowledge and understanding relative to this type of patient to include an awareness of the threat to the patient's femininity and fears associated with an operation.
IDENTIFYING INFORMATION

Name
Address
Age
Marital Statue
Education
Occupation
Religion
Relation of person with whom living
Number in household
Children

Diagnosis
Date of operation
Admitted from
Are there any other cancer patients in family
Specify

PHYSICAL NEEDS: DIAGNOSIS

Age at diagnosis
Where made: Hospital
Clinic
Other (specify)
Date of diagnosis
By whom: Family Physician
Clinic
Hospital
Other

EMOTIONAL NEEDS: ATTITUDE OF PATIENT TOWARD ILLNESS:

Resigned
Depressed
Irritable
Indulged in self pity
Resentful
Defiant
Other (specify)

SPIRITUAL NEEDS:

Religious Affiliation
Catholic
Protestant
Jew
Other (specify)

Is religious belief meaningful to patient?
How often church attended
Participation in activities of Church

REACTION TO DIAGNOSIS:

P A T I E N T

Anxiety
Resentful
Hostile
Depressed
Resigned
Indulged in self pity
Defiant
Indifferent
Other

R E C O R D

44
REACTION TO RECOMMENDATION OF DOCTOR FOR REMOVAL OF BREAST:

PATIENT RECORD

Anxiety
Resentful
Hostile
Depressed
Resigned
Indulges in self pity
Defiant
Indifferent
Cooperative
Wish to cooperate but obstacles
Was not in agreement with recommendation

RECORD OF ADJUSTMENT

A. Kind of person
1. Use illness to accentuate inferiority
2. Use illness to get attention
3. Lose hope easily and become willing to face death or permanent incapacitation

B. Ways and Methods of Patients Reaction to former traumatic and stressful experiences in life
1. Indulges in self pity
2. Self confident
3. Use initiative and ingenuity

FAMILY ADJUSTMENT

1. Interested in welfare of patient
2. Demonstrative in affection to patient
3. Respect the dignity, differences and self-determination of patient
4. Reaction to possible disability of patient

WORK ADJUSTMENT

1. Will illness interfere with employment
2. Relationship with Peers
3. Stability of employment
4. Attitude toward employment

COMMUNITY ADJUSTMENT

1. Participation in activities of community
2. Acceptance by individuals and groups in the community
3. Attitude toward community and its activities
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