A study of the reactions to recommendations of breast surgery by twenty-five women seen in the tumor clinic of receiving hospital, Detroit, Michigan

Willa J. Miller

Follow this and additional works at: http://digitalcommons.auctr.edu/dissertations

Recommended Citation
A STUDY OF THE REACTIONS TO RECOMMENDATIONS OF BREAST SURGERY
BY TWENTY-FIVE WOMEN SEEN IN THE TUMOR CLINIC
OF RECEIVING HOSPITAL, DETROIT, MICHIGAN

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

BY
WILLA JANE MILLER

ATLANTA, GEORGIA
JUNE 1953
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Significance of the Study</td>
<td>1</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>1</td>
</tr>
<tr>
<td>Method of Procedure</td>
<td>6</td>
</tr>
<tr>
<td>Scope and Limitations</td>
<td>7</td>
</tr>
<tr>
<td>II. THE INITIAL REACTIONS OF PATIENTS TO BREAST SURGERY AND FACTORS RELATIVE TO THEM</td>
<td>8</td>
</tr>
<tr>
<td>The Correlation Between the Initial Reaction and the Ultimate Acceptance</td>
<td>13</td>
</tr>
<tr>
<td>Discernible Influencing Factors Relative to the Reaction to the Recommendation</td>
<td>14</td>
</tr>
<tr>
<td>The Relationship of Motherhood and Marriage to the Reaction to the Recommendation</td>
<td>15</td>
</tr>
<tr>
<td>The Relationship of Previous Surgery to the Reactions to the Recommendation</td>
<td>17</td>
</tr>
<tr>
<td>The Relationship of Previous Hospitalizations to the Reaction to the Recommendation</td>
<td>18</td>
</tr>
<tr>
<td>The Relationship of the Age to the Reactions to the Recommendation</td>
<td>19</td>
</tr>
<tr>
<td>III. THE ROLE OF THE SOCIAL WORKER IN WORKING WITH PATIENTS WHO HAVE HAD RECOMMENDATIONS OF BREAST SURGERY</td>
<td>21</td>
</tr>
<tr>
<td>The Worker's Role as Appraiser</td>
<td>22</td>
</tr>
<tr>
<td>The Worker's Role as Interpreter</td>
<td>23</td>
</tr>
<tr>
<td>The Worker's Role as Adviser</td>
<td>24</td>
</tr>
<tr>
<td>The Worker's Role as a Referral Source</td>
<td>24</td>
</tr>
<tr>
<td>The Worker's Specific Role in Working With Breast Surgery Patients</td>
<td>25</td>
</tr>
<tr>
<td>IV. SUMMARY AND CONCLUSIONS</td>
<td>28</td>
</tr>
<tr>
<td>APPENDIX</td>
<td>31</td>
</tr>
<tr>
<td>BIBLIOGRAPHY</td>
<td>34</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Initial Reactions of the Patients to Recommendations of</td>
<td>10</td>
</tr>
<tr>
<td>Breast Surgery</td>
<td></td>
</tr>
<tr>
<td>2. The Correlation Between the Initial Reaction to Breast Surgery</td>
<td>13</td>
</tr>
<tr>
<td>and the Ultimate Acceptance</td>
<td></td>
</tr>
<tr>
<td>3. The Relationship of Motherhood and Marriage to the Reaction to</td>
<td>15</td>
</tr>
<tr>
<td>the Recommendation. Patients Who Were Mothers</td>
<td></td>
</tr>
<tr>
<td>4. The Relationship of Motherhood and Marriage to the Reaction to</td>
<td>15</td>
</tr>
<tr>
<td>the Recommendation. Patients Who Were Not Mothers</td>
<td></td>
</tr>
<tr>
<td>5. The Relationship of Previous Surgery to the Reaction to the</td>
<td>17</td>
</tr>
<tr>
<td>Recommendation</td>
<td></td>
</tr>
<tr>
<td>6. The Relationship of Previous Hospitalizations to the Reactions</td>
<td>18</td>
</tr>
<tr>
<td>to the Recommendations</td>
<td></td>
</tr>
<tr>
<td>7. The Relationship of Age to the Reactions to the Recommendation</td>
<td>19</td>
</tr>
<tr>
<td>for Surgery</td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION

Significance of the Study

The social worker in a medical setting has the responsibility of combining her resources with the other professional staff in the setting who have as their main objective the preservation of life. Though the worker is not equipped with medical skills or a trained appreciation of pathology, she has a tremendous task in helping the patient to accept and see the need for the utilization of these skills. It is increasingly becoming the job of the medical social worker to prepare and aid the patient in the utilization of designated therapy. As the job becomes increasingly hers, the worker's responsibility to the patient is greater. The worker must become aware of the problems, situations, feelings and abilities of patients to accept and utilize medical and surgical therapy. She must know what this treatment means to the patient and she must fully appreciate what it will do to the patient. The worker, therefore, must be prepared to meet and handle a broad area of responses to recommended therapy, and in so doing, consistently benefit the patient.

Modern medical diagnosis and treatment are complicated, expensive, highly technical and successfully carried through only with the intelligent participation of the patient. In this field, the social worker's first contact with the patient comes less often through his own application than other fields of social work; it comes rather through the initiative of others who perceive his medical social needs better than the patient himself.¹

The Tumor Clinic of Detroit Receiving Hospital, where the material for

this study was obtained, is established for the diagnosis and treatment and the follow-up of patients suffering from non-malignant as well as malignant growths. The work of this clinic involves practically all branches of medicine and surgery, but more specifically pathology, operative surgery, therapeutics and roentgenology, including radium therapy.

The establishment of Tumor or Cancer Clinics in the hospitals about the country is under the auspices of the American Cancer Society and the American College of Surgeons, one of their specifications being that a full time social worker be employed. She must be prepared to handle patients who are subjected to a specialized therapy regime and/or disease entity.

The writer, during her training as an advanced field work student in the Tumor Clinic of Detroit Receiving Hospital, observed the occurrence of a high incidence of tumor conditions of the female breast. Generally the treatment of choice in most of these cases was surgery.

Whether or not a tumor condition is benign or malignant determines to a great extent what is to be done to treat it. Because of the similarity of clinical manifestations of the two, the surgical regime by which these patients were treated was often not definitely decided until the patient was on the operating table and the first stages of the operation were performed.

In conditions where there was some question as to the etiology of the condition, the pathologist stepped in to determine it. If the tumor condition was proven benign and of sufficiently little consequence it is removed, but if the condition was determined to be cancerous or malignant, excepting other complications, a radical mastectomy was performed.

For these reasons, in most instances the patient's recommendation for surgery included an explanation of this procedure and preparation for
possible radical mastectomy by the doctor. This varied, however, depending on the doctor's impression of the condition and what it would ultimately require.

It was noted, by the writer, that the women who received these recommendations for breast surgery manifested a variety of reactions, both positive and negative.

It was felt that in order to determine the causes of these reactions, a general understanding of the common factors that are inherent in these situations should be gained.

Surgery, the first common factor considered here, has many diversified meanings to patients, not necessarily in relation to the area of treatment.

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 very 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.¹

Any experience which deviates from the normal or general pattern of life is reacted to on the basis of self-preparedness and the traumatic intensity of the situation.

Surgery is a crisis situation, hence it is natural for a person to have some conflict in facing this situation. It is not unusual for a patient to agree to have an operation and then unconsciously evade it in devious ways. It is also natural for him to fight against the anesthetic too; for the unconsciousness it induces is not only symbolic of death but of putting one's life entirely in the hands of another person - the surgeon.²

² Ibid., p. 24.
The author of the article from which this excerpt was taken has exposed a general and comprehensive appreciation of the meaning of surgery to patients. Any endeavor or experience which may endanger life or limit its entirety is causative of apprehension and anxiety, however, the reactions of persons facing these situations differ as broadly as do their personalities and circumstances. It is not to be forgotten that within this realm of personalities there are those who use and manipulate these situations, depending on their needs. This realization focuses attention on those persons who instead of exhibiting apprehension and anxiety, elect surgery. As to the causes of these reactions, Menninger suggests:

(1) He may wish to avoid facing something else that he fears more than he does surgery. (2) There may be pleasure in submitting to a surgeon who appears strong, dynamic and omnipotent. (3) There may be satisfaction in the punishment from an operation with anxiety being relieved and guilt from unaccepted love wishes being assuaged, and the punishment may be the retaliation for hostile feelings. Some of the other gains from an operation may be sympathy, pity and love that one receives in this situation.1

With an appreciation of the range of reactions to surgery, the value of a more specific approach to the situation becomes more apparent.

Surgery, particularly, has many unconscious meanings for the patient, usually that of mutilation and loss of part of self. Dr. Michaels states that the site of the operation, the disfigurement involved, and the time in the patient's life when the operation takes place, all constitute factors influencing the patient's ability to meet the situation.2

As Dr. Michaels pointed out, 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 here because the breasts are the anticipated area of therapy. Their significance is the second important factor in the group of patients studied here.

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 pubic area 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 un¬quely 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 mis¬leading, since there remains an unshakable and universally uncon¬scious symbolic connection between the breast and motherliness. To threaten the breast is to shake the very core of her feminine orientation.

In no instance, in the general understanding of the meaning of the female breasts to the woman, can we exclude the specific or variable reactions to the female mammary gland.

Women exhibit wide variations in conscious attitudes to their breasts, ranging from extreme pride through indifference to excessive shame. These emotional reactions are partly conditioned by the actual physical appearance of the breasts, whether they are well shaped or unsightly, but primarily they stem from deep psychological attitudes of acceptance or denial of the fundamental feminine role i.e., sex and motherhood.

The mature woman accepts her breasts, whether good or bad, with proportionate amount of pride and utilizes them to their best cosmetic and sexual advantage. She does not feel attitudes of indifference and shame. Later in life, after successful marriage, motherhood and the climacteric — her breasts have less dynamic significance. She has other evidence of her prowess i.e., a husband and children.

With the awareness of the meaning of the two common factors of surgery and the female breast, an appreciation of the basic segments involved in this study is illuminated, thereby, pointing up the significant components of the totality of this study.

The Purpose of the Study

The purposes that the writer hoped to accomplish through this study were to determine: (1) What were the common or divergent factors in the reactions of the patients to the initial recommendations of breast surgery, (2) what, if any, correlation existed between the initial reaction and the ultimate acceptance of the recommendation, (3) what discernible factors seemed to influence the ultimate acceptance of the recommendation and (4) what is the role of the social worker regarding servicing these patients.

Method and Procedure

Interviews with the patients immediately after the doctor made the recommendation were conducted by the writer to obtain material for this study. Medical case histories were used to gain the necessary medical-social history. The Social Service face sheet information revealed the patient's identifying data, family constellation, et cetera.

The cases studied were selected from all those falling into this category during the writer's six month stay in the hospital, which extended from September 2, 1952 until February 27, 1953. The sample was approximately ninety-seven per cent of all the cases falling into this category during this period.

Selected material written in the medical and social work fields was consulted. However, it was learned that relatively little material on
this particular subject was available.

Scope and Limitations

This study was confined to patients seen and treated in the Tumor Clinic of The Detroit Receiving Hospital, Detroit, Michigan. The intake practice of this hospital was limited to emergency and/or indigent patients.

The cases in this study were approximately ninety-seven per cent of all of the cases falling into this category between September 2, 1952 and February 27, 1953.

The reactions appraised in this study were generally limited to one interview which was conducted exclusively by the writer, and observations of the patient-doctor relationship at the time of the recommendation.
CHAPTER II

THE INITIAL REACTIONS OF PATIENTS TO BREAST SURGERY
AND FACTORS RELATIVE TO THEM

In order to point out the range of initial reactions to recommendations of breast surgery, the writer has investigated here the surface of this range, hoping to portray the variety and extensiveness of reactions exhibited by the patients.

The discernible causes for these responses are investigated subsequently in this chapter, however the writer feels that much is to be gained toward a full appreciation of them through the illustrated examination of how some typical patients reacted, regardless of cause.

As Eleanor E. Cockerill has pointed out:

A recommendation for surgery 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 the consequences of not having it. Frequently the case worker is asked to help the patient reach a solution for some of the problems associated with admission to the hospital.¹

The problems involved in the reactions to the recommendations are significant to the medical social worker, as the infrequent and short contacts inherent in the medical setting indicate that an alert and immediate appraisal of the situation is necessary. Kate Holliday has offered some insight into what a patient experiences at the moment when the doctor has prescribed surgical therapy.

The doctor's quiet statement is shocking. Numbly you hear

¹ Eleanor E. Cockerill, op. cit., p. 368.
his quiet voice. Part of your mind protests that this is a scene from a movie. Another part reminds you that the men in white is talking to you; you must face surgery as soon as possible.

'I'll tell the hospital to expect you a week from today.' With those words he has started the machinery. You have begun the ride toward the moment when, unknown to you a knife pierces your skin and over a dozen people whom you have never seen, and perhaps will never see, are hard at work to bring you through the experience safely. Sitting there you feel your first pang of fear.¹

Patients exhibit a variety of reactions to the initial recommendations of breast surgery, which in turn places a variety of demands on the therapist and social worker having contact with them. Any observation of the patients' reactions indicates that a wide range of understanding is necessary.

Although many patients are not told their diagnosis, the recommendation for surgery makes them suspect a 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.²

It is felt by some doctors that all neoplastic conditions should be considered malignant until they are proven benign. With this philosophy many of them hesitate to diagnose a tumor condition until a surgical test has been performed.

Each diagnosis, whether it be of cancer or of any other disease, may activate some preconceived ideas about the disease which are shared by many persons, and each individual patient, of course, reacts to the given diagnosis according to his own particular personality pattern.³

²Carol Cooley, Social Aspects of Illness (Philadelphia, 1951), 56.
In further reference to this type of reaction to a recommendation of surgery for a tumor of the breast, Carol Cooley has pointed out,

A patient may say 'I want to know if I have cancer' or, 'If I have cancer just call the undertaker,' or, 'Don't tell me if I have cancer.' In no instance can the statement be taken literally. The patient who says he wishes to know may fear the diagnosis and really want only confirmation of his hopes that he does not have cancer.¹

In reference to the previous type of situation, the value of an understanding of initial responses to recommendations of breast surgery becomes more significant.

To explore further the components of an initial reaction to a recommendation,

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.²

In reference to the group of twenty-five women studied here, the following table reveals the range of the initial reactions made to the recommendations of breast surgery.

**TABLE 1**

**THE INITIAL REACTIONS OF THE PATIENTS TO RECOMMENDATIONS OF BREAST SURGERY**

<table>
<thead>
<tr>
<th>Group</th>
<th>Reaction</th>
<th>Total</th>
<th>Receptive and Cooperative</th>
<th>Questioning and Hesitant</th>
<th>Refused</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>25</td>
<td>17</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>a</td>
<td></td>
<td>8</td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>b</td>
<td></td>
<td>7</td>
<td>7</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>c</td>
<td></td>
<td>10</td>
<td>4</td>
<td>6</td>
<td>-</td>
</tr>
</tbody>
</table>

¹Carol Cooley, *op. cit.*
²Ibid.
Of this group of twenty-five women, Table 1 shows that seventeen were 'receptive and cooperative' in relation to the recommendation of breast surgery, seven were questioning and hesitant and one patient refused the recommendation.

The type of reactions manifested by the women classified in Table 1 as 'receptive and cooperative group a' who were patients immediately agreeable to the recommended procedure and hospitalization, is found in the following illustration.

Case 5

This patient gave no verbal or emotional indication of anxiety or hesitancy in making a plan for hospital admission. She further indicated her willingness by asking if she might be admitted immediately.

It may be recalled, as shown in Table 1, that of the seventeen patients classed as receptive and cooperative, six were in the group exemplified by the preceding case.

Of the seven patients in this classification who were in group 'b' which included those patients who were agreeable to surgery but who requested from one week to ten days before admission, the following case is typical of the reactions exhibited.

Case 7

This patient showed no anxiety over the proposed surgery, but asked that she be allowed a week before she be asked to accept a bed.

It was noted that four of the patients in the 'receptive and cooperative' classification were in group 'c' this group being those patients who were agreeable to surgery but requested a delay of two weeks to a month before hospital admission. Typical of the 'c' group in this classification was,
Case 13

This patient articulated no fear of the surgery, but voiced an inability to make plans for admission until a later date, which she indicated would be about three weeks.

With the realization that a recommendation for surgery is a crisis situation, it is significant to the writer that of the patients classified as 'receptive and cooperative,' the largest group, requested a slight delay. This type of reaction is consistent with the normality of the need for a short period of adjustment to this type of situation.

As illustrated in Table 1, seven of the patients in this study were classified as 'questioning and hesitant' in relation to the recommendation for breast surgery. In group 'a' under this classification, which included patients who showed obvious emotional indications of anxiety over the recommended therapy, there was one patient. This patient was convinced of the validity of the need for surgery but queried, "Can't it be treated some other way, I am just afraid of a knife."

It was considered significant, by the writer, that of the seven patients in the 'questioning and hesitant' classification six of the patients were included in group 'c,' these being those who were extensively questioning and hesitant in making a plan for admission. These findings seem to indicate that whatever the reason, when patients were questioning and hesitant they were extremely so. An example of this type of reaction is shown in:

Case 3

This patient was extremely fearful that her condition might be cancer. She expressed similar anxiety and fear about the surgery and the anesthetic.

Only one patient in the group studied flatly refused surgery at the time it was proposed. This patient's reaction is illustrated here:
Case 25

This patient stated that her condition did not warrant surgery and further insisted that she was too old to be cut on, this was her breast and she would determine what would happen to it.

In most instances the twenty-five women in this study gave little verbal response to the doctor at the time of the recommendation, however their feelings were more readily discussed and revealed when the plan for admission was talked over with the social worker.

The Correlation Between the Initial Reaction to Breast Surgery and The Ultimate Acceptance

In order to determine the validity of initial reactions to recommendations and how much they were indicative of the patients ultimate acceptance, the writer correlated the two factors.

As the following table shows, of the twenty-five patients studied, twenty followed the recommendation as planned or as their initial reactions indicated and three did not. The patient who refused the recommendation is excluded from this table.

TABLE 2

THE CORRELATION BETWEEN THE INITIAL REACTION TO BREAST SURGERY AND THE ULTIMATE ACCEPTANCE

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Total</th>
<th>As Planned</th>
<th>Did Not Follow Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>24</td>
<td>21</td>
<td>3</td>
</tr>
<tr>
<td>Receptive and Cooperative</td>
<td>17</td>
<td>17</td>
<td>-</td>
</tr>
<tr>
<td>Questioning and Hesitant</td>
<td>7</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>
The three patients who did not accept the plan for admission were in group 'c' of the questioning and hesitant classification. It seemed significant that their initial reactions of poignant anxiety and hesitancy at the time were consistent with their inability to follow through with the plan.

These findings seem to infer that the initial reactions to the recommendation for breast surgery provides a genuine clue to the patient's subsequent response to therapy plans.

**Discernible Influencing Factors Relative to the Reaction to the Recommendation**

With some knowledge of the range of initial reactions, and the high correlation between these and the ultimate acceptance of the recommendation, the discernible contributing factors became of concern to the writer.

In this connection motherhood and marriage were considered as representing the fulfillment of the feminine role. Dr. Renneker, et al., have pointed out, in regard to breast surgery,

The trauma tends to be greater in direct proportion to her comparative youth and the degree of feminine achievement that she feels she has attained i.e., sexuality, husband and children.

The following table reveals findings which the writer feels significantly support Dr. Renneker's theory.

---

TABLE 3

THE RELATIONSHIP OF MOTHERHOOD AND MARRIAGE
TO THE REACTION TO THE RECOMMENDATION

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Patients Who Were Mothers</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Married</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Receptive and Cooperative</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Questioning and Hesitant</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Refused</td>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>

TABLE 4

THE RELATIONSHIP OF MOTHERHOOD AND MARRIAGE
TO THE REACTION TO THE RECOMMENDATION

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Patients Who Were Not Mothers</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Married</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Receptive and Cooperative</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Questioning and Hesitant</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Refused</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

The fact that six of the eight patients who were married and had children were receptive and cooperative to the recommendation for breast surgery, would seemingly indicate that these patients had a feeling of feminine
adequacy and were less traumatized by the proposed surgery.

The two parent patients who were questioning and hesitant about breast surgery presented obvious influencing factors.

Case 5

This patient had one child. Fifteen years prior to her present recommendation for breast surgery, she underwent surgery for the removal of her uterus. This patient was extremely anxious that she might have cancer necessitating a radical mastectomy.

The removal or threatened excision of a secondarily significant sexual organ could be expected to pose more of a threat to this patient's femininity than it would to women not similarly handicapped. (The matter of organ significance will be explored more thoroughly later.)

Case 20

This patient was the mother of three pre-school age children. She knew of no one to whom she could intrust their care for the period of her surgery and convalescence.

The responsibility of this mother to her children and their care cannot be considered a negligible factor. Other than her maternal feelings of protectiveness, the reality of the situation is obvious.

Further exploration of contributing causes in these cases disclosed multiple factors influencing patient's reactions.

The following chart revealed that, of the seventeen patients who were receptive and cooperative, ten had not previously undergone surgery.
TABLE 5
THE RELATIONSHIP OF PREVIOUS SURGERY TO THE REACTION TO THE RECOMMENDATION

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Previous Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
</tr>
<tr>
<td>Receptive and Cooperative</td>
<td>17</td>
</tr>
<tr>
<td>Questioning and Hesitant</td>
<td>7</td>
</tr>
<tr>
<td>Refused</td>
<td>1</td>
</tr>
</tbody>
</table>

For these ten patients with no previous experience provocative of fear, the unknown was apparently more desirable than the current medical state. However, the acceptance and awareness of a need for surgery by the patients may also partially explain this reaction.

It was considered significant by the writer that of the eight patients who had previously undergone surgery, four were questioning and hesitant and four were receptive and cooperative. This division might have resulted from the degree of trauma of the previous surgery. Among the four hesitant patients, the type of surgery performed on one was unknown, however, two had had hysterectomies, and in the other, breast surgery. In relation to how organ significance influences a patient's reaction to surgery, Dr. Michaels has this to say,

In addition to other general factors, the organ involved in the operation plays an important part in the fantasies of the patient. These organs that are especially prone to be invested with conscious and unconscious significance are the generative organs. Experience has shown that operations on the generative organs or organs that may come to symbolize the genital, have more serious reverberations in
the psychic economy than those on other parts of the body. In a woman, the operation may tend to confirm her deeper, inner feelings of being defective.\[^1\]

In relation to previous hospitalizations and their effect on patient's reactions to recommendations of surgery, Kate Holliday says, "What truly upsets them is the unfamiliar hospital routine, in which everyone knows the score but themselves."\[^2\] The following table from this study gives indications of support to this theory. Of the seventeen patients who were receptive and cooperative, twelve had been previously hospitalized.

**TABLE 6**

**THE RELATIONSHIP OF PREVIOUS HOSPITALIZATIONS TO THE REACTIONS TO RECOMMENDATIONS OF BREAST SURGERY**

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Previous Hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
</tr>
<tr>
<td>Receptive and Cooperative</td>
<td>17</td>
</tr>
<tr>
<td>Questioning and Hesitant</td>
<td>7</td>
</tr>
<tr>
<td>Refused</td>
<td>1</td>
</tr>
</tbody>
</table>

The part that age played in the reaction of the patients in this study is revealed in the following table.


\[^2\] Kate Holliday, *op. cit.*, p. 57.
TABLE 7
THE RELATIONSHIP OF AGE TO THE REACTIONS TO THE RECOMMENDATION FOR SURGERY

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Ages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
</tr>
<tr>
<td>Receptive and Cooperative</td>
<td>17</td>
</tr>
<tr>
<td>Questioning and Hesitant</td>
<td>7</td>
</tr>
<tr>
<td>Refused</td>
<td>1</td>
</tr>
</tbody>
</table>

The largest number of patients in this group fell between the ages of seventeen and thirty-one. Of these patients, eight were receptive and cooperative and two were questioning and hesitant. Between the ages of thirty-two and forty-six a similar distribution was noted.

It was considered significant that the largest percentage of questioning and hesitant patients were found between the ages of forty-seven and sixty-one, which includes the climacteric period. In relation to this Dr. Michaels has said.

The time period during which an operation occurs is also important. The first six years of life, puberty and the climacteric are periods during which traumatic events may be much more harmful than at others. This is due to the fact that during each of these periods a shifting in balance of the forces of the personality occur ... With the climacterium there is a feeble attempt by the instinctive forces to assert themselves, so to speak, and a weakening of the restraining forces.

It was the writer's opinion that the high percentage of cooperativeness noted in the patients between the ages of seventeen and forty-six was due to the public health education program which in fairly recent years has made women more cancer conscious, thereby alerting them to the signs of cancer.
and the results of hesitancy in heeding them.
CHAPTER III

THE ROLE OF THE SOCIAL WORKER IN WORKING WITH PATIENTS WHO HAVE HAD RECOMMENDATIONS OF BREAST SURGERY

The preceding chapters of this study were an attempt to discern the factors influencing patients' reactions to recommendations for breast surgery. With some insight into this problem, the writer gave attention to the realm of the social worker in these situations and possible methods of working with these patients more effectively.

Most medical social workers, because of their customary position in the out-patient department of a hospital, make contact with a considerable number of the institution's patients at a strategic point in their ongoing medical care. Many of these patients have come to the social worker's attention because they are having difficulty in carrying through their medical care. As her skill increases she should be increasingly able to help in sifting out those patients whose emotional problems are most significant and most closely related to their medical care, especially in general clinics, which are themselves sifting centers from which patients are sent on to specialized services, since the preventive value of such insight into a person's need is greatest in the early stages of treatment.\(^1\)

In regard to her role it should be kept in mind,

There are certain distinguishing features of medical social work which need to be stressed. It is supplementary to medicine which means that the process is always one of team work with the physician, and frequently with other professional persons, such as the nurse and the dietitian. The hospital is a complex institution, the administration of which has many social aspects. Illness means fear, pain, disability, sometimes stigma for the patient and creates many problems for his family.\(^2\)

With this knowledge of the setting and its component parts the medical social worker is better equipped to define her position and meet her responsibilities.

---

\(^1\) Harriett M. Bartlett, "Emotional Elements in Illness: Responsibilities of the Medical Social Worker," The Family, XXI (April, 1950), 65.

In relation to patients who have had recommendations of surgery, who possibly exhibit one or more of a variety of responses she has a position of (1) Appraising the patient, her situation and abilities; (2) interpreting the setting, the physical condition and the therapy in terms of her understanding; (3) advising in relation to the patients' needs and (4) employing and directing patients to supplementary resources as the needs arise.

In reference to appraising the patient and her situation:

When she observes a patient who, perhaps shows an excessive emotional reaction to some relatively simple difficulty or who blocks continually in taking certain steps, or is extremely dependent, or manifests other signs of possible emotional problems, the worker will be able to share her observations with the physician and thus add to his picture of the patient material perhaps not otherwise available to him. In some instances, the worker's contribution will end here and the major steps in carrying through the subsequent treatment, as related to these emotional needs, will naturally fall to the physician and the psychiatrist. In other instances she will share in the subsequent treatment.¹

The need for the physician to know the patient he treats can never be under emphasized. The worker's role in making this possible has been illuminated in the preceding excerpt. In order to adequately make known the components of the personality to the physician, the worker must develop an alert understanding herself.

Instead of resting on trial and error, categorical treatment, or intuition, as formerly, present case treatment is based on a wider understanding of the person's needs and the role which the worker herself plays. In any environment, such as that of the hospital, where urgency, tension and fear are so prevalent, we see again and again in our cases the great value to the patient that comes through a quiet attitude of poise and security on the social worker's part. Many times it seems that this intangible factor is more important than any specific action of the social

¹ Harriett Bartlett, op. cit., p. 37.
The value of an analysis or appraisal of the individual personality for interpretation to the physician as seen in the twenty-five cases in this study, might be exemplified by the patient who flatly refused surgery at the time it was proposed to her. In subsequent contacts with this patient it was obvious that she maintained ignorance of her disease, and was extremely upset by her routine physical examination. With a better appreciation of the emotional components of this patient's personality, her specific needs would have been more adequately ascertained and interpreted to the physician, who then should have been better equipped to plan for and treat this patient in regard to her individual requirements.

The Worker's Role as Interpreter

As an interpreter to the patient facing breast surgery, the worker may best dispel the accompanying fears by emphasizing the necessity for the prescribed therapy comparing the negatives with the positives of the prognosis. By making the patient aware of the setting she is to become part of and the processes to which she will be exposed, the worker allows the patient to develop some degree of preparedness and confidence.

Fears related to illness and medical care are so common that often they are not given sufficient consideration. They have their basis in the patient's past and should be acknowledged as very real to him, for only then can he be helped to dispel them.\(^1\)

In further reference to the medical social worker's role as an interpreter to breast surgery patients, it has been judged valid that the worker

---

\(^1\) Harriett M. Bartlett, *op. cit.*., p. 39.

\(^2\) Carol Cooley, *op. cit.*., p. 29.
Acquaint her with the encouraging details of her prognosis, and with her role in the total treatment. Explain all the necessary therapeutic steps, such as biopsy, mastectomy, and radiation, and why they are important. Pay attention to the status of her emotional health, do not allow her to build up and retain unnecessary fears and feelings of inevitable death. Explain the need for entering the treatment period prepared.

The Worker's Role as Adviser

In regard to the worker's role as an adviser, Eleanor Cockerill has said: "The social worker in her helpful capacity as an adviser should be able to insist that no delay can be tolerated in obtaining proper treatment."

However, it is always to be remembered that in regard to a therapy regime the final decision should be that of the patient. Nevertheless, the worker's knowledge of what is most beneficial to the patient should not be denied the patient.

The Worker's Role as a Referral Source

The social worker in any setting should be a referral source. With the range of situations, social or otherwise, coming to her attention, she must be adequately prepared to direct patients to sources where needs beyond the agency's function might be met.

An instance in which the worker's role as a referral source is exhibited is when a patient's abilities to accept hospitalization for breast surgery

---

2. Renneker, et. al., op. cit., p. 354.
are limited by the problem of the care of her children during her treatment period and convalescence. At this point the awareness of agencies set up to provide the service and the ability to use it is exclusively the social worker's tool.

The Worker's Specific Role in Working With Breast Surgery Patients

With a general appreciation of her role in working with patients, the social worker's more specific role in handling patients facing breast surgery is indicated.

With the awareness that this type of operation is a specific threat to a patient's sexual and feminine adequacy, the worker must be prepared to give considerable understanding and support. She must never lose sight of the dynamics involved here and she must tune her skills to sympathetic handling of the patient and her associated problems.

The worker must be aware of the fears associated with tumor conditions and their relation to malignant processes and she must be prepared to help the patient verbalize her fears and work them through in order to prevent an emotional block to her surgical recommendation.

Still more specifically, the worker should be aware of the basic pathological processes of malignant and non-malignant tumor conditions and the therapy regimes thereby connected. With this knowledge she can sincerely allay some of the patient's fears. Such knowledge that breast surgery is seldom anticipated unless the prognosis is good or unless the patient will somehow be benefitted, is the type she should acquire.

Some awareness of the patient's past medical-social history is indispensable to the worker's most effective preparedness for facing these patients
and availing them with adequate services. The knowledge of their reactions to previous surgery and the type of surgery undergone serves as a clue and a basis for further treatment of the patient. Some insight into the patient’s reaction to illnesses and her needs relative to them further fortifies the worker’s treatment approach. It is the worker’s role in regard to the acquisition of this information, to investigate case history information and/or to employ case history taking techniques in the obtaining of same.

In regard to the relative trauma associated with this attack on the patient’s breast, the worker must appraise the patient from the standpoint of her self acceptance and maturity in order to establish the patient’s needs and to provide for adequate handling of them.

The role of the social worker in working with female patients facing breast surgery includes, then,

The use of specific knowledge and skills in addition to the generic. The medical social aspects of the situation become the focus of attention. The term connotes the relationship of the two factors. Medical social problems exist when either the medical aspects in a case situation impinge on the social or the social aspects or the medical, or both.1

In summary it is agreed,

When case work is practiced under medical auspices certain emphases are to be expected, since the purpose of the institution, its staffing and concerns are primarily medical not social care. The well-equipped case worker in or outside the medical institution has to comprehend the meaning of symptoms, to understand disease processes within the personality, the effect of disability on social functioning, and the typical expressions of anxiety and dependency in illness.

The young doctor must balance his medical training by learning to see the patient as a person; the social worker by learning to see the person as a patient. In the strictly

---

medical setting the accent on illness and disability means deepening one's understanding of the body-mind unity; recognition of the course and treatment of major pathological syndromes, mental and physical; evaluating the possibilities of maintaining or regaining health; providing convalescence, special treatments, terminal care, communicability, and community aspects of illness and public health.¹

CHAPTER IV

SUMMARY AND CONCLUSIONS

Because of the variety of reactions to recommendations of breast surgery observed by the writer during her advanced field work placement at the Detroit Receiving Hospital, Detroit, Michigan, it became the writer's intention to learn something of the components of these reactions; the discernible factors and the relatedness between the initial reactions to and ultimate acceptance of the recommended therapy.

Various factors investigated in this study led the writer to draw some inferences 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 and future study on the subject.

It was felt, by the writer, that the hospital setting was of secondary importance as a contributing factor and the emphasis was placed on other factors which seemed contributory to these women's reactions to breast surgery.

Primarily, the meanings of surgery and the breast were considered significant in the approach to the study. First, surgery was considered as having many diversified meanings to patients regardless of the organ of treatment. Surgery was considered a crisis situation and reactions of conflict in facing it were considered normal. The more specific reasons for the various reactions exhibited were explored from a general frame of reference.

The breasts, being a sexual symbol, seemed a contributing factor to
patients' reactions to surgery. It was generally concluded that the breast had two psychological meanings to the patient, a symbol of femininity and a milk bearing or nourishment providing organ. This dual significance of the breast was considered of great importance in the approach to this study.

A wide range of reactions to breast surgery was observed in patients although the largest number of patients was receptive and cooperative in relation to the recommendation. Of this number the largest proportion were in the group of patients who requested a delay in surgery from one week to ten days.

It was also noted that of the patients who were questioning and hesitant, nearly all of them or six out of seven were in the most extreme group of this category.

The correlation between the initial reaction and the ultimate acceptance was significantly high. Of the twenty-five patients, twenty accepted the surgery as planned. Of the four patients who did not, three were extremely questioning and hesitant and the other flatly refused surgery at the time it was proposed.

In regard to the factors contributing to responses it was found that the largest number of receptive and cooperative patients 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 breast's symbolism.

In regard to the effect of previous surgery on the reaction of the patients to the recommendation of breast surgery, it was discovered that ten of the seventeen patients who were receptive had not previously undergone surgery; the inference in relation to these findings being that this number
of patients either were maturely aware of the need for surgery or that the unknown was more desirable than the present medical state.

Of the seventeen patients who had previously been hospitalized, twelve were receptive and cooperative with an awareness of the setting and/or service seeming to facilitate patients acceptance of the recommendation.

The factor of age and its influence on the patients' reactions in this study drew interest to the group of patients who were most resistive. These patients were those where age suggested the climacterium. On the basis that this period is normally traumatic for femininity, these reactions seemed explainable.

It was also noted that patients between the ages of seventeen and forty-six were most receptive, which the writer partially attributed to influences of the active public health education program which has existed during the impressive years of these patients lives.

The role of the social worker in working with patients recommended for surgery was ascertained as fourfold: (1) Analyzing the situation, the patient and her abilities; (2) interpreting the setting, the physical condition and therapy in terms of her understanding; (3) advising the patient in relation to her needs and (4) employing and directing the patients to supplementary resources as the needs arose.

Over and above this general approach it was felt that the worker in handling this special type of patient needed to acquire additional knowledge and understanding relative to this type of patient, to include an awareness of (1) the threat to the patient's femininity and sexuality, (2) the fears associated with the possible malignancy of a tumor condition, (3) the pathological processes of tumor conditions and (4) previous medical-social history.
<table>
<thead>
<tr>
<th>Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name __________________________ Age ____________________</td>
</tr>
<tr>
<td>2. Sex _______ Race ____________ Marital Status ______</td>
</tr>
<tr>
<td>3. Relatives ____________________________________________</td>
</tr>
<tr>
<td>4. Classification ______________________________________</td>
</tr>
<tr>
<td>5. Chief Complaint ______________________________________</td>
</tr>
<tr>
<td>6. Present Illness ________________________________________</td>
</tr>
<tr>
<td>7. Past History __________________________________________</td>
</tr>
<tr>
<td>8. Clinical Diagnosis ____________________________________</td>
</tr>
<tr>
<td>9. Recommended by Tumor Service __________________________</td>
</tr>
<tr>
<td>10. Summary of patient's response to the doctor at the time the recommendation was made ______________________</td>
</tr>
<tr>
<td>11. Patient's reaction to case worker's question as to when she will be able to accept hospitalization ___________________</td>
</tr>
<tr>
<td>12. Summary of ensuing interview between worker and patient ____________________________________________________</td>
</tr>
<tr>
<td>13. Plan discussed and made __________________________________</td>
</tr>
<tr>
<td>14. How patient worked through with plan:</td>
</tr>
<tr>
<td>a. Did patient file application for medical care. If so, how soon</td>
</tr>
</tbody>
</table>

32
b. Did patient accept a hospital bed the first time it was offered? __________ If not, why ________________

c. Length of time after first bed was offered that patient accepted admission.

15. Summary of all or any contacts made with patient after the recommendation for surgery and before hospital admission __________________________

_____________________________
BIBLIOGRAPHY

Books


Articles


