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COPING WITH AND ADJUSTING TO MASTECTOMY AND WIDOWHOOD A COMPARATIVE STUDY

A thesis presented in partial fulfilment
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ABSTRACT

A comparison of two cross-sectional surveys of thirty women who had undergone mastectomy with thirty widows established that both losses were met with a similar initial grief reaction which moved through the stages of denial, alarm reaction, realisation and resolution, and manifesting most of the features of the normal acute grief reaction as outlined by Lindemann (1944).

Significant differences between the samples in the duration of the reaction were established however. Fantasies of rejection and stigmatisation on the part of the women who had had mastectomies were not realised. Women in supportive primary relationships who regained and maintained physical health reported that they quickly re-established a normal outward lifestyle. Breast loss was not found to affect all other aspects of the woman's life in the same way as the loss of a husband does.

Many women reported combinations of complex feelings in their intimate relationships, and attributed their being able to manage these emotions and confine them mainly to the physical realm, to the acceptance and support of their husbands.

Most of the mastectomy sample reported that the threat of a recurrence of cancer and its possible consequences was sufficient to be the focus of long periods of intense and painful preoccupation, and remained with them to some degree, but so long as they remained physically well they were usually able to employ a denial strategy and not dwell upon the matter.

Widows and those in less supportive marriage situations within the mastectomy sample coped least well with their loss, were prone to prolonged invalidism, were less satisfied with their breast prostheses, seemed to be less motivated to resume a normal life-style and were less able to control their emotions. For widows mastectomy reactivated and intensified their reaction to the loss of their husband.

Women confronting mastectomy appeared to be able to make some use of forewarning as indicated by a reported absence of emotional numbing at the time of the actual loss on the part of half of the sample. Widows did not appear to be able to similarly guard against initial emotional numbing. Forewarning could not be demonstrated to influence subsequent adjustment to loss in either circumstances.

PREFACE

" Once you have had this experience you are never the same again. You can understand how others feel in the same situation."

Widow.

Death and illness arouse fear in us. They remind us that we will surely die, and that we may lose the people we love. If we choose to deal with fear by turning away from it we not only deny others our comfort and support, but we deny ourselves the opportunity to prepare for life events which are inevitable for most of us.

The experience of talking in depth with over 60 women about their grief (which I admit I approached with some initial trepidation) has been a rich one for me. I am humbled by their strengh of courage and perseverence against severe odds.

ACKNOWLEDGEMENTS

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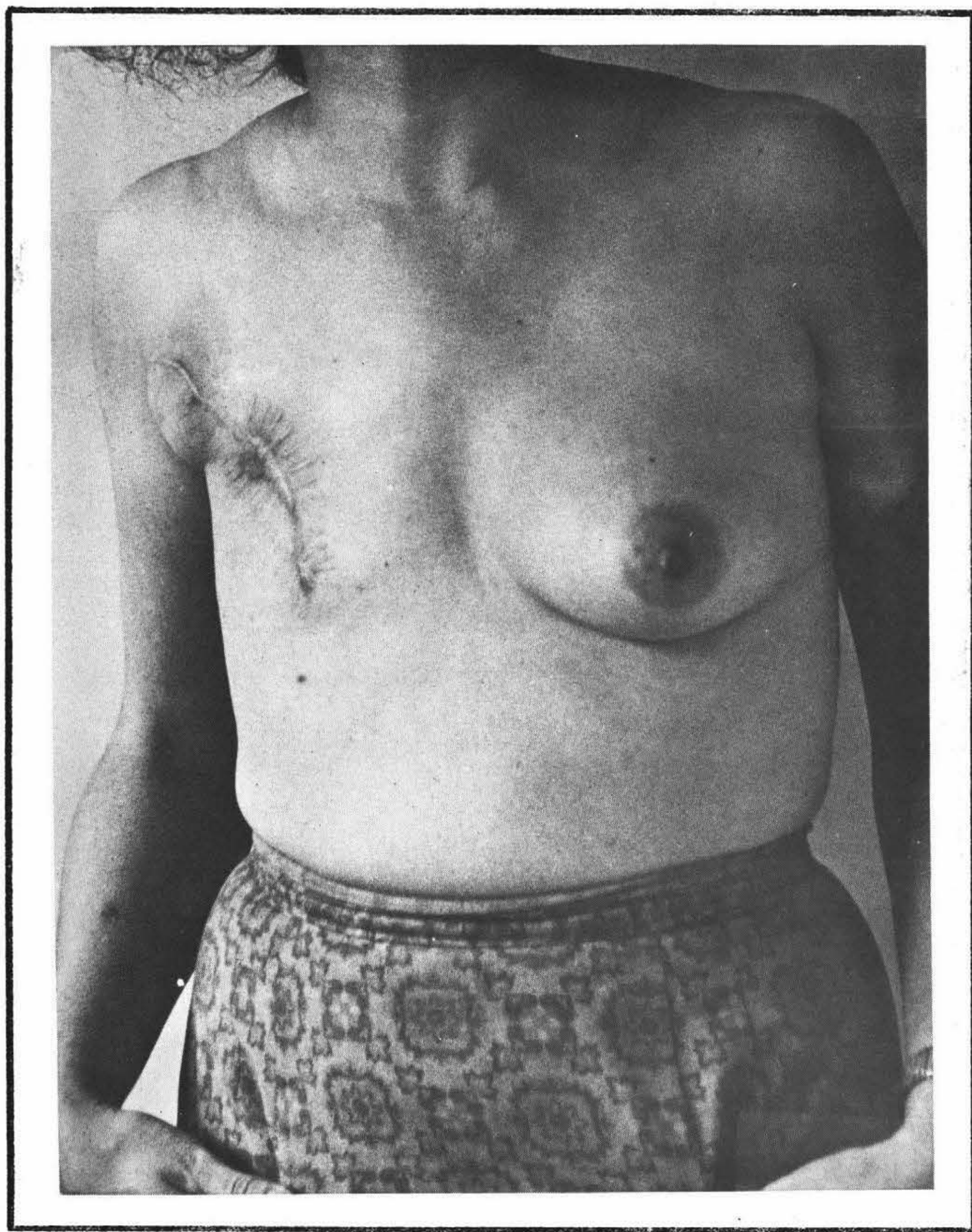

FIGURE 1

An example of the residual scar resulting from a modified radical mastectomy.

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INTRODUCTION

Until fairly recently little research has been done into women's issues. This is probably because researchers tend to investigate areas that interest them, that they feel confident about, and most researchers are male.

As a woman in my thirties, interested in the subject of women, and having the opportunity to carry out a study for a masters thesis, I felt that I was in a good position to investigate two commonly occurring events which affect women's lives: the mastectomy experience and widowhood. These are usually regarded as very sensitive areas, and one, the mastectomy experience, has had little systematic attention paid to it. I hoped to be able to establish the kind of relationship with women from these two groups necessary to encourage them to share their experiences in a way a younger woman, or a man, possibly could not.

To become a widow at some stage in her life is one of the most likely experiences for the New Zealand woman who marries. The social norm of women marrying men on average two years older than themselves, and the greater life expectancy for women (75 years for Pakeha women as against 69 years for Pakeha men) are largely responsible. (New Zealand Year Book; 1977) Widows greatly outnumber

widowers; 72 per cent of all widowed persons are women. (The 1971 Census gives as widowed 104,533 females and 26,798 males.)

Breast cancer, for which the primary treatment is mastectomy, is the most common cancer in New Zealand women. It constitutes 25.3 per cent of the incidence of all cancers in women (Cancer Data, 1976 Edition) and is responsible for 20 per cent of all cancer deaths in women (New Zealand Year Book; 1977). Approximately one New Zealand woman in twenty will develop breast cancer in a life time, more frequently between 40 years and 70 years. In these terms mastectomy is also a common experience for women.

Studies in the area of widowhood have come to place more emphasis on the social and emotional components of the reaction to it. Various approaches have been used. Lindemann (1944) outlined the psychological and physiological symptoms of acute grief, Averill (1968) included widowhood in his outline of the biological significance of the grief reaction, Parkes (1972) approached it as a psychosocial transition, Marris (1958) studied various consequences of bereavement, Lopata (1973) studied a younger group in terms of widowhood as a social and emotional event, and Glick et al (1974) concern themselves with the changing roles and statuses of young widows, and how they come to terms with their loss.

The report of observations of the psychological impact of cancer and adaptation to mastectomy by Bard and Sutherland (1955) is the most detailed and comprehensive work available in this area. The psychological and emotional reactions to breast cancer and mastectomy are frequently recognised by writers of articles for medical and nursing journals, but references to these aspects are usually cursory, as their focus is primarily on patient management and medical, surgical and nursing procedures.

My aim is to contribute to the understanding of the responses of those coping with these two difficult experiences, approaching them primarily from the perspectives of the women themselves; to understand the experience from their point of view. Thus the focus is on the conscious experience accessible to introspection and recall, rather than on unconscious processes. It is hoped that what is lost in the individual's recall of the event will be made up for by the insights she has subsequently gained from the experience. For example the woman may recognise in retrospect that she employed denial as a coping strategy; something she would not have been aware of, or able to articulate at the time.

More specifically it is hoped that within the terms of the features, symptoms and stages of the normal grief reaction, the following areas will be better understood:

1. To what degree can the immediate reaction to the mastectomy experience be compared with the reaction to being widowed?
2. Does forewarning of the event influence the reaction?
3. What social factors contribute to, or block the readjustment of women in these circumstances?

Originally it was hoped that 40 women from each category would be interviewed. However with the full assistance of the Medical Records Department at the Palmerston North Public Hospital a total of 30 women who had undergone mastectomy within the last 13 years were found to be available for interviewing. A corresponding 30 widows were subsequently interviewed, with a view to confirming the basic findings of other studies of widows, thus providing a basis for comparison with the mastectomy group.

Considering the fact that I interviewed all 60 women myself and taking into account time and money factors (I spent no less than 1.5 hours, and usually between 2 and 3 hours with each woman, and travelled up to 40 miles to 17 of the women living in the area around Palmerston North) the size of the samples compare favourably with those of other studies; Parkes (1964a) Harvard Study with 49 widows and 19 widowers, Parkes (1964b) study of 44 widows, Parkes' (1965) Bethlem Study of 21 bereaved subjects, Parkes' (1970b) London Study of 22 widows,

Glick et al's (1974) study of 49 widows and 19 widowers, and Bard and Sutherland's (1955) study of 20 women who had had mastectomies.