

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

**COPING WITH AND ADJUSTING TO
MASTECTOMY AND WIDOWHOOD
A COMPARATIVE STUDY**

**A thesis presented in partial fulfilment
of the requirements for the degree of
Master of Arts
in Psychology
at Massey University**

**Diana Mary Parsons
1979**

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 strength of courage and perseverance against severe odds.

ACKNOWLEDGEMENTS

Thanks are due to John Stuart of the Medical Records Department at the Palmerston North Public Hospital without whose willing assistance the interviews with women who have undergone mastectomy would not have been possible, Mr. J. M. Hay whose concern for his patients motivated him to initiate contact with the appropriate people at P.N.P.H. on my behalf, the many friends and acquaintances who helped to locate widows willing to be interviewed, Mike Smith, my supervisor, to whom I am grateful for support, guidance and constructive criticism, my husband Red, my children Simon and Anton who have shown patience without which the study would not have been completed, Susan Gray who typed the manuscripts so excellently, but most of all I am grateful to all of the women who agreed to share their stressful experience with a person they had not met before, in the hope that others might gain from an increased understanding of the area of loss.



FIGURE 1

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

TABLE OF CONTENTS

	<u>PAGE</u>
ABSTRACT	ii
PREFACE	iv
ACKNOWLEDGEMENTS	v
FIGURE I	vi
LIST OF TABLES	ix
INTRODUCTION	1
<u>PART ONE</u>	
CHAPTER I Adaptation And Coping	6
CHAPTER II Grief	20
CHAPTER III Widowhood : An Event With Severe Consequences	28
CHAPTER IV Variables Which Affect Widowhood Grief And Adjustment	33
CHAPTER V Widowhood And the Stages of Grief	43
CHAPTER VI The Mastectomy Experience	64
<u>PART TWO</u>	
CHAPTER VII The Study, Aims, Hypotheses and Method	83
Questionnaires	107
CHAPTER VIII Results	119
CHAPTER IX Discussion of Results	192
Conclusion	217
PRACTICAL RECOMMENDATIONS	218
APPENDICES : 1. Introductory Letter to Mastectomy Women	220
2. Reminder Letter to Mastectomy Women	222
3. Raw Data : Comparison Between Mastectomy and other Event, Widowhood and other Event, Using 9 Point Scale From Unbearable (1) to Bearable (9)	223
4. Incidence of Some Common Features in Studies of Widows	224
BIBLIOGRAPHY	226

LIST OF FIGURES

<u>FIGURE</u>	<u>TITLE</u>	<u>PAGE</u>
I	An example of the residual scar resulting from a modified radical mastectomy.	
VIII : 1	Recovery Over Time From Preoccupation With Loss : Mastectomy And Widows Samples	131
VIII : 2	Recovery Over Time From Increased Tearfulness After Mastectomy And Husband's Death	151
VIII : 3 SERIES	Duration Of Various Physiological and Psychological Symptoms Over Time in Mastectomy and Widows Groups	
VIII : 3a	Loss of Appetite	155
VIII : 3b	Lump in Throat	156
VIII : 3c	Butterflies in Stomach	157
VIII : 3d	Weight Loss	158
VIII : 3f	Difficulty Getting Off To Sleep	159
VIII : 3g	Disturbed Sleep	160
VIII : 3j	Lack of Concentration	162
VIII : 3k	Restlessness	163
VIII : 3l	Irritability	164
VIII : 3m	Inability To Make Decisions	165

LIST OF TABLES

<u>TABLE</u>	<u>TITLE</u>	<u>PAGE</u>
VII : 1	Mastectomy Sample : How Contacted	92
VII : 2	Number of Women Working at Time of Interview	96
VII : 3	Number of Subjects in Each Age Group At Time of Mastectomy and Widowhood On-set	96
VII : 4	Number of Subjects - Time Since Mastectomy and Widowhood On-set; At Time of Interview	98
VIII : 1	Number of Subjects in Mastectomy and Widows Sample Who Were Forewarned of Their Loss	120
VIII : 2	Initial Reaction To Forewarning and Actual Event : Mastectomy and Widows Sample	120
VIII : 3	First Realisation of Fact of Loss After Event : Mastectomy and Widows	124
VIII : 4	Rating of Own Reaction To Mastectomy and Widowhood Experience on 9 Point Scale : Emotional Impact and Recovery Effort Involved	135
VIII : 5	Continuing Sense of the Presence of Breast and Dead Husband	142
VIII : 6	Changes in Cigarette Smoking Habits During First Year of Widowhood and After Mastectomy	168
VIII : 7	Frequency of Use of Sedatives, Tranquillizers and Hypnotics After Mastectomy and Husband's Death	169

<u>TABLE</u>	<u>TITLE</u>	<u>PAGE</u>
VIII : 8	Percentages of Mastectomy and Widows Samples Perceiving Social and Emotional Reactions in Others	172
VIII : 9	Predominant Feelings About Self, Personal Development and the Changes Brought About by Mastectomy and Widowhood	179
VIII : 10	Mastectomy Sample : Satisfaction with Prosthesis	185
VIII : 11	Remarriage As Seen By Widows	185

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.

PART ONE

CHAPTER 1

ADAPTATION AND COPING

ADAPTATION

White (1974) describes adaptation as the master concept in any discussion of the strategies man uses to survive the demands the environment may place upon him. Adaptation can be seen as a state reached, or as a process. In a sense all behaviour can be considered an attempt at adaptation. Even in easy times mechanical and habitual behaviour is not usually adequate. Adaptation under relatively difficult conditions, where a fairly drastic change, or a problem presents itself, defies familiar ways of behaving and requires the individual to produce new behaviour. Such demands usually give rise to uncomfortable emotions like fear, distress, anger and shame.

In dealing with situations where the individual perceives a threat to himself he is said to be coping. Moos and Tsu (1976) say there are two related tasks in coping; responding to the requirements of the external situation, and also to the feelings one has about that situation. These two tasks are not necessarily dealt with simultaneously. The coping process is dynamic, and the demands of the situation change as time passes, as do the strategies of the individual.

According to Lazarus (1966), the greater the anticipated harm the greater the threat, and the more intense will be the consequent emotion and effort to cope. The presence of threat implies an evaluation by the affected individual, usually based on past experience. The more hopeless and powerless a person feels about potential harm the more threatened he will be.

The individual continually searches, sifts through and evaluates the cues in any given situation. According to Lazarus (1966) appraisal takes place in three phases. Primary appraisal evaluates whether a situation is potentially harmful, beneficial or not to be worried about. Secondary appraisal looks at the range of actions which could master the threat. Reappraisal, the third aspect, is a response to changing external or internal cues, and is about changes in the original perception, say from harmless to threatening. It depends upon new cues, thoughts about the original perception, or feedback from the individual's own reaction to the situation. Such mediating appraisals explain the visible variety of coping strategies and reactions to threat.

Asch (1952) discusses the fact that it is within man's capabilities to look forward and backward, and perceive casual relations. He can anticipate the consequences of his actions. James (1892) saw man as self conscious in

that he is an object to himself, aware of his individuality. He has an attitude towards himself and strives to control his own actions and tendencies. White (1974) calls the balanced state of man's awareness of the remote, the past, the future and his awareness of himself as a person, the "internal organisation". He regards the maintenance, and if possible the enhancement of a satisfactory self picture as of great importance if the individual is to cope. In an unfamiliar situation the individual may wonder what sort of an impression he is making, how well or badly he is dealing with that set of circumstances, or how he appears in the eyes of others. When self-esteem is threatened, or when a situation is very challenging, even small doubts about one's competence to deal with the situation can precipitate shame, which in turn further threatens one's internal organisation.

On the basis of man's ability to realistically look forward and backward there is a probability that some form of warning assists the individual to begin to adapt to a threat or a new set of circumstances before an event occurs. In presenting information to an individual in manageable amounts before the impact of a threatening circumstance comes about, anticipatory sorting out and preparation can be done without the trauma of the event itself.

Janis (1958, 1971) believes that from studies of people

facing major surgery, debilitating illness and community disasters, comes a pointer for a need for some kind of emotional inoculation. In studies done by Caplan (1961), Egbert et al (1964), Janis (1958) and Janis and Levanthal (1965), there emerges an indication that if a normal person is given accurate warning of impending pain and discomfort, together with sufficient reassurances so that fear does not mount to very high levels, he will be less likely to develop acute emotional disturbances afterwards, than the person who receives no prior warning. There are obvious exceptions, for example, some neurotic personalities who are hypersensitive to any threat cues. But in the main, moderate fear arousal, according to Janis (1958, 1971) functions as a kind of emotional inoculation enabling normal people to increase their tolerance for stress by developing effective coping means in advance of the event.

In the Harvard Study of widows and widowers under 45 years, Parkes (1972) divided subjects into those who had only a short time to prepare themselves for the death of their spouses (less than two week's warning coupled with a terminal incapacity for the spouse of less than three days) and those who had a longer time (a terminal incapacity of more than three days, whatever the period of warning).

During the first month of bereavement short preparation for death was significantly related to an immediate reaction of

disbelief, feelings of anxiety, self-reproach and depression. 46 per cent of this group said they did not care whether they lived or died, or expressed some positive wish for their own death, as compared with 15 per cent of those who had had some time to prepare.

One year later those who had had little preparation time appeared to be more pessimistic about the future, more inclined to tearfulness and more anxious and depressed than the group who had had a longer preparation period. Only 13 per cent of those with short preparation time were rated as having a good overall outcome. 59 per cent of those who had had time to prepare were so rated.

In White's (1974) view the maintenance of an acceptable degree of autonomy, or space to move about in is vital to the coping process. Closely related to this need is the requirement for a manageable amount of information upon which to make decisions about possible actions. It is not the actual volume of information that counts, but rather its meaning in terms of potential benefits and harm. In some circumstances it is appropriate to secure more information, while in others it is necessary to cut down the input. An individual may be in a position where adaptation to a severely distressing reality is possible only if full recognition of the bitter truth is postponed for a long time.

THE ROLE OF DEFENSES IN ADAPTATION, INCLUDING DENIAL

The relationship between the degree of threat perceived and the tendency to employ more primitive or desperate types of coping processes means that more direct, more obviously adaptive, and more reality-oriented forms of coping occur when the threat is fairly mild. The more primitive means of coping are usually classified as defenses. Menninger (1954) organized defenses on a continuum of increasing "primitivisation" and disintegration, ranging from what he called first order defenses, which included efforts at self-control, increased alertness and vigilance, to fifth order defenses where control was lost and death resulted. Miller and Swanson (1960) also classify defenses according to their consequences. They use two classifications. One class contains simple defenses, associated with maximum distortion of reality, found in a range of circumstances, which produce social difficulties or maladjustment. Denial is an example, and is considered to be more primitive than the defenses of the second class. Here there is less distortion involved, the likelihood of social difficulties is less, but the defenses are more complex. They include displacement or projection. Extreme or prolonged stress brings about the first class defense.

Two questions arise. When can defenses be regarded as adaptive? Is there a difference between defense and denial?

It is generally agreed that defenses have a legitimate place among strategies of adaptation. Mechanic (1974) defines defense as a set of mechanisms that facilitates continuing performance and mastery, but although they may be very successful in diminishing pain and discomfort, they may be catastrophic for personal adaptation if they retard action towards real threat.

Denial is seen to be one of the major aspects of psychotic states (Waelder, 1960; Lewin, 1950; Fenichel, 1945). It is suggested by Hackett and Cassem (1974) that behavioural scientists have come to regard denial as a primitive defense and to view it as indicating a serious underlying psychopathology. This belief is challenged by a number of investigators. (Weisman, 1972; Hackett and Cassem, 1974; Aitken-Swan and Easson, 1959; Engel, 1962; Gilbertson and Wangenstein, 1962; and Croog et al, 1971). They have found denial of an extreme nature to be commonly used by otherwise normal and stable people as part of coping with serious illness. Investigations of coping in cancer and myocardial infarction patients by Hackett and Cassem (1974) revealed denial as the most common defense and the most effective in reducing anxiety. In another coronary care unit study they found that those who managed to deny the most had better survival records.

Weisman (1972) challenges A. Freud's (1946) stand that denial is a unifying concept and a goal. He says that

denial is only one aspect of defense. It can be conceptualised dynamically, as a process, where negation and aversion are not held as static states; or mechanically as a fact with the one purpose - to avoid painful perceptions.

A mechanistic interpretation of denial assumes that denial is not within the conscious control of the individual.

SOME SOCIAL FACTORS WHICH AFFECT ADAPTATION

Social psychology has had an effect upon the way adaptation is viewed according to McGrath (1970). No longer is adaptation considered in terms of the external environment and the individual's resources to deal with it. The social aspects of man's existence must also be included. Social demands do have an influence upon the outcomes of man's coping attempts. He is dependent upon others. Mechanic (1974) believes the individual's abilities to cope with the environment depend upon the efficiency of the solutions his culture provides. The strength of the individual's psychological capacities count for little so long as the preparation available in that culture, and the social support systems are inadequate. According to Adams and Lindemann (1974) the success or otherwise of any planned strategy is always determined by the social context in which it is carried out. The vital question is for whom is the individual adjusting?

Weisman and Hackett (1967) believe that denial is under the conscious control of the individual. They believe that it has a social function; to deliberately prevent the loss of a significant relationship. Individuals tend to deny more to some people than to others. People who deny a great deal usually do so to protect a high self-esteem. Thus they keep contact with those significant to them. Particularly vulnerable to the threat of becoming insignificant survivors (Weisman 1967) are the terminally ill, who have to contend with a threatening disease and the impairment of their personal significance. They may deny the seriousness of their condition to friends and relations in order not to distress them and themselves so as to maintain a normal relationship with them, thus encouraging significant people to continue visiting.

In an investigation into the relationship between the need for approval and perceptual defenses Conn and Crowne (1964) found that approval seeking individuals were inclined to protect and enhance their vulnerable self-esteem by conforming to other people's wishes and behaviours.

MEASURING DENIAL

Hackett and Cassem (1974) have constructed a rating scale to measure denial, based on the qualities thought to characterise a major denier. Close observations of the verbal and non-verbal behaviours of a group of coronary patients were

recorded during extensive interviews about their fear responses during their present hospitalisation and during their past life experiences.

As a group they shared a tendency to deny verbally, a tendency to minimise or displace symptoms to other organ systems, and a tendency to down-play danger, displacing the threat to other objects, or projecting their fear. They displayed a jovial hearty manner, debunking worry and using cliches whenever asked about death. (e.g., " If your number is on the ticket, you've got to buy it ".) Verbal dismissal of fear was often accompanied by a shrug or the waving of an arm.

Strict criteria made it difficult for subjects to qualify as major or minimal deniers. If a person admitted to being frightened even once in his life he could not be classified as a major denier. To qualify as a minimal denier the individual had to readily admit fear and lack any consistent defensive tactic against it, which meant that only those with an almost constant awareness of generalised fear fitted the criteria. Those in the middle were called partial deniers. Out of 89 patients 21 were classified as major deniers, 65 as partial deniers and only 3 as minimal deniers.

This rating scale was designed for use in the hospital setting with patients in a life-threatening situation. With modifications the scale could be used over time and in different

social contexts to gauge changes in the frequency and degree of denial usage.

THE INTROSPECTIVE OR VERBAL REPORT

Although many criticisms can be legitimately levelled at the verbal or introspective report most investigators feel it is the only access available to certain information.

(Bozeman et al, 1955; Lazarus, 1966; Haigh, 1949; Mechanic and Newton, 1965.) Before discussing the introspective

report any further though, it is as well to keep in mind the warnings of Korchin and Ruff (1964) and Mechanic (1974).

They suggest that there are individuals who do not have a great degree of "accessibility to self", and that there is no good evidence that a high level of self-awareness or introspection is related to successful adaptation. On the contrary, they contend there is reason to believe that successful coping is actually retarded by these. Many successful copers "tend to be rather insensitive to their own intrapsychic experience and tend to orient themselves more to their outer environment than to their inner world". Because they see complexities in every issue some individuals find it difficult to mobilise to actively deal with anything. It follows that at least some successful copers will not be able to give much information about their feelings or strategies during their coping.

17

In her study of the adaptation of mothers to the threatened loss of their children through leukemia, Bozeman et al (1954) relied on recall to a considerable extent. They assert that since recall of affectively laden events is more reconstruction than reproduction, much of the data they gathered represented selective emphasis on the part of the mothers. The continued stress of the experience and the manner in which the mothers adapted to their situation must also have had an influence on their recall. These investigators took this kind of distortion into account when reporting their findings.

According to Lazarus (1966) there are no methods of obtaining information on affects which are free of error. Behavioural and physiological alternatives are not well enough developed to distinguish between affects, and despite the fact that social constraints, differences in meanings of terms between individuals, and defenses introduce sources of error into their measurement, the introspective report yields information which would otherwise be inaccessible. The solution is not to abandon introspective report, but to find ways of minimizing, eliminating or taking into account the distortions that do occur.

One way of minimizing the types of distortion usually associated with social pressures is to provide an atmosphere of acceptance. Rogers' client-centred approach is based on a permissive

relationships where non-possessive warmth and accurate empathy are of paramount importance in that they do not interfere with the subjects' perceptions and recall. Haigh (1949) in a study of defensive behaviour, employed the Rogerian approach and found that it reduced defensiveness because the individual's "sense of worth" was not threatened.

Haigh's work extended over a considerable time-span, with long term contact with subjects. The success of the Rogerian approach in short-term contact, especially when in-depth information about affect-laden events is hoped for, may be queried. However Lazarus (1966) suggests that the Rogerian views would probably be that it is not so much the amount of contact that matters, as the kind of contact.

The effects of the time factor in studies relying on recall deserve attention. Casey et al (1967), Mechanic (1965) and National Health Survey investigators (1963) have been concerned with the validity of recall over time and have made some findings which seem to be unrelated to reasonality or demographic characteristics. Mechanic (1965) found that in health interview studies, serious disorders which require repeated attention were more salient than less serious ones, and were more likely to be reported accurately. Investigators with the National

Health Survey (1963) found that minor illnesses were subject to more memory bias and recall variability than those which had affected the life of the individual to the extent that one or more specific forms of action had been taken, including the restriction of usual activities, disability, work load, seeking medical advice, or taking medicines. These actions represented a significant change in the ongoing life pattern of the individual. Casey et al (1967) investigated consistency of recall and in relation to the saliency of life events, using the Scale of Recent Experiences where each item has an assigned value according to its magnitude of significance as established by Holmes and Rahe (1967). Going back over ten years 54 subjects recorded the year certain events took place, and the number of times each year certain events had occurred. Nine months later the same 54 subjects repeated the exercise thus providing 54 paired sets of records. It was established that the most significant determinant affecting the consistency of recall and the validity of recall, was the mean item value. This value indicates the salience which each item has for the individual in terms of the degree of change and adaptability required for him to meet the event in the life situation. Casey et al infer that consistency of recall may indirectly reflect recall validity.

CHAPTER II

GRIEF

GRIEF DEFINED

"Grief reaction", or "grief process" are terms reserved for coping with the loss of a significant object. Typically this object is another person, a spouse or a child, but it may also be one's own life, part of one's body, wealth, a home or a freedom. The grief process was first reported in full by Lindemann (1944) and later fully delineated as an evolved biological adaptive mechanism by Averill (1968). Volkart (1957) sees "separation reaction" as being the more general phenomenon in which grief reactions are but one type.

Because the coping sequence which follows bereavement or some extremely difficult loss situation is more obvious, uniform and universal in its nature than other forms of coping it is easier, according to Falek and Britton (1974) to observe its onset and sequence, and to identify its components. They are of the opinion that the coping sequence often called the "grief process" is a universal reaction to any change in the established steady state great enough to produce stress in the organism and occurs to some degree to major as well as minor traumas throughout life.

A consistent pattern of grief reaction has been described by a number of authors under a variety of circumstances. (Aldrich, 1963; Bard, 1952; Bowlby, 1960, 1961, 1963; Bozeman et al, 1955; Brewster, 1952; Caine, 1974; Cogswell, 1967; Fisher, 1960; Fried, 1963; Gorer, 1965; Gut, 1974; Hamburg and Hamburg, 1953; Kastenbaum, 1969; Kennell et al, 1970; Kubler-Ross, 1969; Lifton, 1954, 1967; Lindemann, 1944; Marris, 1958; Parkes, 1964b, 1965, 1970a,b, 1972; Schilder, 1951; Solnit and Stach, 1961; Sutherland, 1952; Visotsky et al, 1961; Weisman, 1972; Weiner, 1970; Wolfenstein, 1957; Wretmark, 1959).

Averill (1968) points to cross-cultural studies which indicate that the initial emotional response and ensuing sequence of grief reaction stages is relatively invariant, even though the expression, depth and duration do vary in different cultures.

Like other emotional concepts grief is context specific; the grief-stricken individual and the occasion for the grief should be examined. The culture the individual lives in determines the social relationships, like family or kinship systems, of any society. Social practice therefore dictates the gravity of say, the loss of a spouse. Volkart and Michael (1957) describe the social structure in the Trobriand Islands where the most significant family relationships are between maternal kin. Greater grief is experienced when close maternal relatives die than when a spouse dies.

Most investigators identify a number of stages in the development of the reaction. The minimum number would be the three general stages as used by Averill (1968).

Many phases within or between these general stages are distinguishable.

Parkes (1972) describes grief as involving a succession of clinical pictures which blend into and replace one another. In general terms "numbness, the first stage, gives place to pining, and pining to depression and it is only after the stage of depression that recovery occurs. "

Kubler-Ross (1969) uses five stages to outline the process worked through by dying persons; denial and isolation, anger, bargaining, depression, and acceptance. Different writers identify and emphasise various stages more or less, according to the circumstances of their study. Not all individuals show the same degree of severity of psychological or physiological reaction, nor exactly the same symptoms. In some cases a stage may not manifest itself. Falek and Britton (1974) state it is common for the progression of stages to be repeated in cyclic fashion with diminishing intensity upon each repetition, or for a fluctuation to occur between two or more of the phases.

Psychoanalytic Interpretation

From the psychoanalytic viewpoint the grief process is as follows. Development of the individual is accompanied by attachment or cathexis of libidinal energy to signif-

icant persons or objects. The libidinal ties must be broken if the cathected object is lost. As this is a painful and difficult task resistance or denial of loss is evident. However reality testing makes denial untenable. In order to protect the ego from being overwhelmed by the pain of the emotions experienced, decathexis proceeds piecemeal with the aid of introjection in which the relationship with the lost object is internalised. Thus the relationship is preserved even though many of the libidinal ties are abandoned.

ADAPTATION AND GRIEF

The consistent pattern in coping behaviour within and between cultures for a range of stressful loss experiences, lends support to the notion that such behaviour is of biological origin. Observations of grief-like reactions in the animal world also points to this. Averill (1968) identifies grief as being fundamentally a biological phenomenon the significance of which extends further than the well-being of the individual. He hypothesises that the function of grief is related to the maintenance of long-term social bonds which ensure the survival of the species. This is how he reasons. Separation from the group, or from specific members of the group, is a painful and stressing experience. It is punishing for the isolated person and for other significant individuals remaining within the group. Thus the isolated individual is motivated to relieve his discomfort and re-join the group. Past history, the peculiar

circumstances of the individual as well as the customs and mores of the society he lives in will have an influence upon the grief process.

In support of his biological orientation to grief Averill (1968) cites the work of Eibl-Eibesfeldt (1967) on three forms of animal social organisation; the aggregation, the anonymous group and the individualised group. The last one is held together by bond of individual acquaintance and attachment, and grief-like reactions have been observed in animals of this social type.

Averill (1968), Bowlby (1961), Lindemann (1944) and Wretmark (1959) see the breaking of a mother-child relationship as being a "natural" occasion for grief, in that it has important biological consequences. Grief-like reactions have been observed in subhuman primates when mother-infant relationships have been dissolved. Carpenter (1942) describes two rhesus monkeys who carried their dead babies until only skins and skeletons were left.

Averill (1968) believes there is also a biological basis for the grief of one adult for another in that the co-operative behaviour of adults in the care of the young provided the basis for the first social contact in animals.

GRIEF AND MOURNING

The terms "grief" and "mourning" are often used interchangeably. Freud (1917) used the word "mourning" in his work on bereavement behaviour for both the affect of grief and its outward manifestations.

The two terms have come to have more precise meanings. Mourning has come to describe the culturally prescribed public expression of sorrow, while grief refers to the stereotyped set of psychological and physiological reactions personally experienced by the individual in response to the loss of a love object.

The two response patterns may occur independently of each other. Although no response ever occurs in isolation from social and cultural influences, a grief reaction may, according to Averill (1968), occur in circumstances where there is no set of mourning practices prescribed. On the other hand mourning in ritual form may be enacted with little or no affective involvement.

Averill (1968), Gorer (1965) and Parkes (1972) see mourning rituals generally as complementing the grief process. Using a bereavement situation as an example Averill follows the sequence of funeral rites of a people of South India, the Kotas, as described by Mandelbaum (1959). He illustrates Gorer's observation that in some cultures mourning customs in the form of

a series of ceremonies over time closely parallel the basic stages of grief. Social recognition is given to initial shock with first funeral rites at the "Green Funeral" attended only by those close to the deceased. A period of some months follows where the bereaved are left in quiet, fitting in with the depression stage of grief. A second ceremony, the "Dry Funeral" takes place in the Kota society every one or two years for all of those who have died since the last ceremony. Its purpose is to encourage the bereaved to give full expression to their grief, and gradually over the eleven days of the ritual, less sombre activities are engaged in. These encourage the bereaved to resume their roles as members of society.

In his study of grief and mourning Gorer (1965) found that the majority of contemporary Britons suffer a lack of help and guidance in the crises of misery and loneliness which occur in almost everybody's life. He cites the decline in formal religious belief and ritual as removing an important form of guidance. In the absence of legitimate formal expression of grief in ritual form the individual does not have the opportunity to express his emotions or experience the support that ritual provides, and is placed in a position where he is more vulnerable to pathological reactions. Society does not have the means by which to assist the individual in his grief.

Also writing about the British context Parkes (1972) notes that the "cultural evolution that has made marriage an integral part of our social organisation has done little to ensure that the functions that it performs will be adequately carried out after its dissolution".

FEATURES OF GRIEF

Averill (1968) summarizes the major features of grief as a complex but stereotyped response to the well-defined situation of real or imagined loss of a significant object. Accompanying psychological and physiological symptoms are alleviated when new object relations are established. It is a ubiquitous phenomenon among humans and appears in other social species as well. Grief is extremely stressful yet behaviour during grief is often antithetical to the establishment of new relations, and hence the alleviation of the stress.

CHAPTER III

WIDOWHOOD : AN EVENT WITH SEVERE CONSEQUENCES. INCREASED ILLNESS AND MORTALITY AS INDICATORS OF THE SEVERITY OF EFFECTS OF WIDOWHOOD.

Various investigators have noted an increased susceptibility to psychological and physical ill health, and an increased likelihood of death within the first year of bereavement, on the part of the widowed. It is generally agreed that such outcomes are probably the consequences of the stress normally associated with the loss of husband and the ensuing changes to the widow's life.

Marris (1958) found that nearly half of his sample of widows two and a half years later considered they sustained lasting ill health since their husbands' death, Parkes (1964) reports that widows under 65 years consulted their doctors with psychiatric symptoms more than three times as often as controls, Maddison and Viola (1968) found that Boston widows sustained three times the marked ill health as controls and Sydney widows fifteen times the amount of ill health as controls.

Maddison and Viola (1968) found little change in the incidence of major diseases including those which are generally believed to be at least partly psychosomatic in origin.

However Lindemann (1945) and McDermott and Cobb (1939) report increases in certain serious diseases after bereavement. Schmale and Ilker (1966) found that on the basis of a patient's report of having responded to a life event prior to the first cervical smear with feelings of hopelessness a psychiatrist was able to predict a diagnosis of cervical cancer more frequently than two times out of three. The life events preceeding the disease were usually seen as irrevocable losses by the patient.

INCREASED RISK OF MORTALITY

A statistical relationship exists between bereavement and an increase in the death rate but the reasons for this are unclear. Heart disease is the main cause of death.

Young et al (1963) discovered a 40 per cent increase in the death rate among 4,486 English and Welsh widowers over the age of 54 years during the first six months of bereavement. 75 per cent of this increase was attributable to heart disease. After six months the death rate dropped off to be about the same as the mortality rate for married men of the same age. Parkes (1972) says the relationship between bereavement and increased heart disease is not understood, but speculates that an existing condition could be aggravated by the physiological symptoms of stress, or by alterations to diet, or increased smoking.

In Rees and Lutkins' (1967) study of a semi-rural Welsh community the death rate within one year of bereavement for widows and widowers was 12 per cent as compared with 4.8 per cent of other bereaved persons. 0.7 per cent of non-bereaved persons of the same age died in the same period. The risk of the bereaved relative dying within one year was more than twice as high if the relative died suddenly in a hospital, as opposed to slowly at home.

At every age, according to Kraus and Lilienfeld (1959) widowed persons are more likely to die than married persons, and the excess in risk is greater in the younger ages. Widowers are more likely to die than widows.

WIDOWHOOD IN THE CONTEXT OF OTHER LIFE EVENTS

Holmes and Rahe (1967) have established a scale of life events called the Social Readjustment Rating Scale (S.R.R.S.). A large number of life events were arbitrarily assessed by several populations, in terms of the intensity of emotion at the time of their occurrence, and the time taken to recover from the events. One event was used as a reference point, and other events were ordered according to whether each assessor felt the event to be more or less generally severe. Numbers of "life-change-units" were subsequently assigned to each event, based on the values given to each event by

the original assessors. An increase in a variety of physical or psychological complaints is more likely if the individual experiences a period of high scoring in life-change-units (L.C.U.).

Death of a spouse holds first rank on the S.R.R.S. and is valued at 100 L.C.U. The second rank is occupied by divorce with 73 L.C.U. (less than 75 per cent the adjustment value), jail term with 63 L.C.U., personal injury or illness with 53 L.C.U. and marriage in seventh rank with 50 L.C.U. Marriage then, can be said to be half as disruptive as the death of a spouse. 37 other events are valued between 47 and 11 L.C.U., but many of these are often also present for say the bereaved spouse, as repercussions of the first event, for example; change in financial state, change in living conditions, revision of personal habits, change in recreation, change in social activities, change in sleeping habits. A life crisis is said to have occurred when 150 L.C.U. or more are accumulated within one year.

Holmes and Masuda (1974) postulate that life change events can evoke adaptive efforts by the human organism which are faulty in kind and duration, "bodily resistance" is lowered, and the probability of disease occurrence is increased.

It is primarily on the basis of the fact that the loss of a spouse is ranked first on the S.R.R.S., that it is heavily loaded in terms of life-change-units, and that other life-events inevitably accompany it, that widowhood onset and the coping process following, is to be used as a means of illustrating and elaborating upon the stages of the grief process.

CHAPTER IV

VARIABLES WHICH AFFECT WIDOWHOOD GRIEF AND ADJUSTMENT

INTERRELATED VARIABLES

At the outset it is well to emphasise that although the grief process is a sequence of stages, these stages do not automatically "happen" to a passive, bereaved woman. Lindemann(1944) re-stated what Freud(1917) intimated; that the satisfactory outcome of the grief process depends upon the success with which the individual does her "griefwork". Gut (1974) refutes the notion that "time heals all wounds" and points out that a great deal of effort and concentration are needed by the widow in order to succeed in dealing with what may well be the hardest task of her life.

Gut (1974) lists variables which she feels, influence the course and outcome of grief. In terms of widowhood they are :

1. The social interaction between a woman and her husband in terms of intensity, function, scope and subjectively experienced quality.
2. The woman's "inner image" of her husband as related to how she feels about his appearance, abilities, values and behaviours.
3. The nature of the husband's death including the

length of forewarning, the opportunity to take farewell of him and the nature of his last illness.

4. The widow's personality as related to her level of maturity, the degree to which she is able to tolerate frustration, conflict, depression and feelings of powerlessness. Related to these are less ambiguous factors such as the widow's age, state of health, and previous loss experiences.
5. The widow's social situation which involves the presence or absence of meaningful friends, the cultural patterns governing the expression of thought and affect related to loss and death, and the availability of socially valuable roles which facilitate the re-orientation of the widow's sense of meaning essential to her identity.
6. Changes in economic status.

THE MARRIAGE RELATIONSHIP

Gut (1974) points out differences between the parent-child relationship (the prototype for attachment and "natural" grief in biological terms); she says the course of the relationship between child and parent is normally completed and dissolved before separation by death. Conversely successful marriage is never completed in all its functions (parenting is only one function) and is often developing when it is severed by death. The adaptation that facilitated optimum interaction prior to bereavement becomes a liability. The widow finds herself ill-equipped to lead a satisfactory life as a single person.

Attention to the findings of various investigators in the areas of sex-role socialisation, marriage and friendship patterns will provide support for this view.

STEREOTYPES AND SEX-ROLE SOCIALISATION

Broverman et al (1975) in a study of the effects of stereotypes on judgement of mental health, found that psychologists, psychiatrists and social workers alike make a clear-cut distinction between the healthy man and the healthy woman. The healthy woman is more submissive, less independent, less aggressive, less competitive and more emotional than the healthy man. Broverman et al state :

" In our society, men and women are systematically trained, practically from birth on, to fulfill different social roles. An adjustment notion of health plus the existence of differential norms of male and female behaviour in our society, automatically lead to a double standard of health".

They go on to state from their findings that the healthy male is not seen as being different from the healthy adult, where as the adult and feminine concepts of health do differ significantly. Women are placed in a conflict situation where they must decide whether to exhibit these positive characteristics considered desirable for men and adults, and thus have their "femininity" questioned; or to conform to the prescribed feminine behaviour role and accept second-class status.

Hacker (1975) in an updated version of her classical 1951 article on women as a minority group specifies the similarities between women and other minority groups, particularly blacks in the United States, which include feelings of inferiority and a tendency to self-criticism. She makes special mention of the "marginal woman" who suffers the conflict of being torn between accepting and rejecting traditional roles. Hacker believes that despite increasing interest in women's roles and a growth in women's groups the majority of American women do not wish to change their traditional sex-roles.

Whether or not Hacker's minority group view of women is accepted a picture emerges from various studies of woman as one who denies at least some of her innate abilities, constrains her personality, suffers a sense of powerlessness, puts great store on her married status and feels over-responsible for the state of happiness or otherwise in the marriage.

NON-COMPETITIVE, DEPENDENT ROLE

Horner (1970) in her investigation of university students found that female academic success was disapproved of by both male and female students. Horner identifies the differences in achievement and performance between men and women as a sex-role socialisation factor manifest in females as a fear of success.

Kangas and Bradway (1971) point to the tendency on the part of women of higher intelligence to gain fewer I.Q. points than women of lower intelligence between the ages of 12 years and the mid 20's. Men similarly categorised show a greater increase for the more highly intelligent group. Kangas and Bradway interpret this to mean that some categories of women use their intelligence to become less intelligent, at least in early adulthood.

Sontag (1958) in a longitudinal study of 72 women and 59 men found that women who were highly social and dependent were more likely to have declining I.Q's as measured on the Otis Test, than those who were less characteristically sex-typed.

Ross (1973) found that the married state tended to cause women to constrict their personalities in preference to displeasing their husbands. A study of academically able women university students showed that those who had been married tended to be more dependent, less spontaneous, more submissive and more conservative than their unmarried counterparts.

ORIENTATION TO THE ENVIRONMENT

Women tend to see their relationship to the environment differently from men.

20

Neugarten (1964) and Rotter (1966) found that where men at all ages tend to believe that their power to control their fate resides within themselves, women tend to believe that powers outside of themselves control them in an almost magical way. Troll (1975) suggest that this general feeling of powerlessness leads to a tendency in women to distort reality so as to convince themselves that what they have is what they want.

In a study of turning points in life Lowenthal and Chiriboga (1972) found that women regarded the commencement and breaking of ties with significant persons as being crucial, while men emphasized educational and occupational achievement and changes.

MARRIAGE AND ROLE

Neugarten (1968) identifies both an age-role identity and a sex-role identity. Society exerts pressure upon the individual to behave in certain "appropriate" ways at given ages. Non-conformity to such pressure brings about feelings of failure, guilt and shame. Neugarten talks about a "social clock" which governs when it is appropriate to marry, to have a first child and so on. Women are expected to marry and have children at a younger age than men. By doing so they conform to an age-sex-role.

Munstein (1972) found that the social cost of abstaining

from marriage was greater for women than men.

Men have greater control over marital choice than women, in that women have a shorter age range of marriageability and a longer life span. Thus they are more available and less in demand. Social expectation dictates that men take the more active role in initiating relationships between the sexes. Women feel more comfortable in a dependent role.

ROLE DIFFERENTIATION SOCIAL CLASS AND MARRIAGE

Troll (1975) writes that in the traditional working class marriage the husband is expected to earn a living and protect the family from the outside world, while the wife is supposed to raise the children and maintain a smoothly running home. There is little expectation of love, warmth, emotional support, shared thoughts or interests within the couple. The wife relies upon her sisters and neighbours for these. In the middle class marriage however, these are primary expectations with less role differentiation.

SATISFACTION, HAPPINESS AND MARRIAGE

Women's expectations from marriage tend to be different from those of men. Bernard (1973) asserts that marriage is primary to a woman's self-esteem but secondary to man's. Women not only report more stress in the marital situation, but more overall satisfaction. Men generally report

satisfaction with marriage so long as other aspects of their lives are satisfactory, but for women dissatisfaction spreads to other aspects of their lives from marital unhappiness.

Tharp (1963) found that when a husband is unhappy the couple is unhappy, but a wife's unhappiness does not seem to transfer to her husband in the same way.

Bernard (1973) came to the conclusion that women can make a full-time career of keeping the husband happy.

FRIENDSHIP PATTERNS

Babchuk and Bates (1963) found that married adults have two sets of friends; those of the same sex whose interests are similar, and those they call "family friends", who are couples with whom the husband's interests or jobs they have in common. Although for visiting and recreational purposes family friends may be the most often associated with, they are not usually the most intimate and congenial friends for either spouse.

This is the typical pattern for the middle classes.

According to Babchuk and Bates (1963), Adams and Butler (1967) and Hess (1972) lower class couples tend to have fewer family friends, and most of their social interaction take place in sex-segregated groups, and primarily with

relatives and neighbours. Most adults tend to have only three or four personal friends.

According to Haan and Day (1974) with advancing age people tend to become less gregarious. Troll (1975) believes that people tend to maintain their personal friendships but cut down on the number of acquaintances.

Hess (1972) attempts to identify what friendship does for the psychological well-being of the individual. He considers that it serves as an anchorage for individual integration within the larger society, and provides emotional support and stability of self-image. Lowenthal and Haven (1968) found that old people who are able to maintain at least one intimate relationship can survive the drastic losses that accompany aging; losses that send the desolate friendless to the mental hospital.

Jones (1974) reports a greater degree of intimacy between women than men, supporting the notion that society more readily permits women to express emotion and relate to each other and to men on an emotional basis.

Social and geographical mobility tend to necessitate changes in friends. Toffler (1970) argues that people in fact have a strong need to avoid close ties with others in a rapidly changing society.

At the same time the social isolation brought about by such mobility increases dependence within the couple.

CHAPTER V

WIDOWHOOD AND THE STAGES OF GRIEF

The following sequence closely resembles that outlined by Parkes (1972) and proceeds from shock and denial, to searching, to anger, shame and guilt, to depression, (which can be seen to be the second major stage in the general movement from disbelief to realisation), and finally to the stage of resolution, or the establishment of a new identity.

SHOCK AND AVOIDANCE

Almost without exception the widow's usual response to news of her husband's death takes the form of a protest that it cannot be so or that some mistake has been made. Accompanying this is shock. This is often described as a numbness, an emptiness, dazedness, non-comprehension in personal terms. Glick et al (1974) describe this state of numbness as constituting a brief moratorium from feeling, a time when the widow can know as a kind of external fact that her husband has died, but does not yet have to deal with the fact at an emotional level. Glick et al say it would be inaccurate to suggest that all emotional recognition of loss is prevented by this shock reaction. Recognition and acceptance of the loss

of husband seems rather to proceed in fits and starts, "now succumbing to denial, now re-emerging in response to insistent reality".

Falek and Britton (1974) describe this non-comprehension as the action of denial mechanisms which reduce the impact of the sudden trauma and prepare the widow for cognitive acceptance of the situation. Reality testing usually forces cognitive awareness upon the individual within a short time.

Lindemann (1944) reports an all pervading sense of unreality, an increased emotional distance from others even to the point where the widow experiences a distorted visual perception of others who may appear small or shadowy, and an intense preoccupation with the physical image of the dead husband. Sometimes this preoccupation causes fear in the widow who registers the conflict she feels about the finality of the death and the continuing presence of the husband's physical image as approaching insanity.

Cognitive awareness is manifested in the form of alarm reaction. In general terms this can be seen as a state of acute alertness. Emotions are redundant for at least some of this stage. Typically a high level of general arousal with corresponding changes in the sympathetic part of the autonomic nervous system occur; rapid beating

of the heart, increased respiratory rate, increased muscle tension, increased sweating, improved vision and the mobilisation of energy resources. Non-essential functions cease. A lack of appetite, nausea, digestive disturbances and weight loss occur and may persist for long periods. Nineteen of the twenty-two widows in Parkes' (1971) London Study lost their appetites in their first month of bereavement and fifteen of these experienced recognisable weight loss. Sleep disturbances are also to be expected. Seventeen widows in the London Study reported insomnia, thirteen of them experiencing severe problems with getting off to sleep and if they did, waking during the night or very early in the morning. For five of these widows such sleeplessness persisted beyond a year.

In the same study eighteen of the twenty-two widows interviewed reported a state of high general arousal and restlessness, and fourteen of them described episodes of feeling panic-stricken. Parkes (1972) identifies these episodes of acute symptoms as the most characteristic feature of grief, and calls them "pangs". Pangs are the wave-like engulfing periods of severe anxiety and psychological pain when the widow strongly misses her last husband and sobs or cries aloud for him. Parkes found that such pangs of grief typically begin within a few hours or days of bereavement and usually reach a peak of severity within five to fourteen days. Initially they occur frequently and spontaneously but later on they

become less frequent and are precipitated by some identifiable occurrence that reminds the widow of her loss.

Glick et al (1974) interpret weeping and crying as the expression of sorrow. 92 per cent of their sample cried during the first week after their husband's death. 19 per cent said they cried for extended periods, while the remaining 73 per cent cried intermittently.

Parkes (1971) believes that widows in the London Study cried as an expression of helplessness, but also with their husbands as its object. Only 6 of the 22 widows in his study did not cry when discussing their bereavement one month after their husbands' death.

The episodic nature of this intense subjective distress or mental pain and tension is also described by Lindemann (1944). He reports that waves of these symptoms are brought on by visits, mentioning the deceased, and receiving sympathy. Lindemann identified a tendency on the part of the bereaved to avoid this syndrome by refusing visits and deliberately not thinking about the deceased.

The widow can be said to initially deny the fact of her husband's death, and then when it is no longer possible to do this, to try to deny the painful feelings associated with it.

Visits from friends and relatives serve as a reminder of the unwelcome fact that the husband has died. Their presence is frequently met with hostility coldness and irritability by the widow who, according to Lindemann (1944) may, herself, be at a loss to why she should behave in this way. Attempts to handle these reactions in combination with continuing shock, often result in a formalised and stiff manner in social interaction.

SEARCHING

Lindemann (1944), Glick et al (1974), Parkes (1972) and Averill (1968) account for the restlessness, the constant and apparently aimless movement, the inability to sit still, usually evident in the newly bereaved widow as the biologically programmed behaviour of searching.

Parkes (1972) points out that a great deal of animal and human behaviour contains elements of searching. The constant reassessments the individual must make to keep up to date with the requirements of any changing set of circumstances can be called searching. In ethological terms orienting stimuli guide behaviour towards a set-goal, and consummatory stimuli bring a sequence of behaviour to an end. In goal situations that are continuous over time, as is the case with the maintenance of a marriage relationship a special type of ongoing activity is continued. In the case of the widow the

behaviours which used to ensure the maintenance of the relationship now no longer work, but behaviours established as habits over years persist in her repertoire.

C.S. Lewis (1961) describes the frustration which results from unconsummated strivings as a feeling of suspense; a feeling that something is about to happen. When another person has been so integrally a part of so many aspects of one's own existence, the loss of that person brings about an awareness of how much he or she was the target of much feeling behaviour.

Lindemann (1944) also observes that the widow while clinging to the daily routines, "goes through the motions" but is surprised to find that a large part of her customary activity was done in some meaningful relationship to her husband, and has now lost its significance.

Parkes (1972) found that the grieving widow's state of alertness, restlessness, preoccupation and set to find the lost husband, lead her to pay attention to places and activities most closely associated with him. The fact that it is obviously pointless and irrational to search for the dead husband does not stop the widow's compulsion to seek him out. Such is her preoccupation with looking for him that she "recognises" him even when what she sees is only an approximate fit to her

picture of him. Parke's (1972) widows in the London Study often described illusions of having seen or heard their dead husbands. Widows, scanning the faces of men in the street, would think they saw him in the distance, or would "see" him in a car similar to the one he drove, in his chair, or in bed. Noises in the house at night would be interpreted as the sounds of the husband entering the house. Widows who had nursed their husband through his last illness would often continue to hear his call or cough in the night.

Bowlby (1969), in his study of attachment has shown that attachments are formed through the senses; touching, hearing, seeing and smelling. Dominian (1976) says it is to be expected that such sensations will form the basic link between the bereaved and the dead when something happens to evoke the presence of the dead person.

Glick et al (1974) found that the greater part of their sample seemed to maintain a sense of their husband's presence for the first two months of their bereavement. This ranged from vague feelings to actual hallucinatory experience, and was felt to be a comforting presence while it lasted. When the illusion was broken though the widow often felt distressed and cried.

According to Glick et al the most important determinant of the sense of presence of the deceased was whether the death had been anticipated. There were nine widows in

the sample who, a year after the death, reported a continuous sense of the presence of their husband. All nine had suffered unforewarned bereavement . A follow-up two to four years after bereavement revealed that the same nine widows still had a sense of their husband's presence, but for only two was it continuous still.

Glick et al speculate that the absence of opportunity to prepare themselves for the loss seemed to predispose these widows to the development of such a fantasy relationship. They say it could be that these were particularly dependent wives. In any case these widows remained committed to idealisations of their husbands and their marriage long after other widows had adjusted to new life styles.

ANGER, SHAME AND GUILT

Searching for the irretrievable husband inevitably gives way to frustration. Anger is one of the most common known responses to frustration. This anger is often turned inwards upon the widow herself in the form of guilt.

Freud (1917) and Rochlin (1973) reason that because the bereaved woman values the dead husband she is put into a position of feeling guilty for being angry at him for causing her to suffer. Her guilt resembles remorse.

The crying associated with the anger phase of grief is

interpreted by Averill (1968) to be a secondary reaction to the pain and frustration experienced by the bereaved. However, Averill believes it is typically absent during the phases of abject grief and depression.

Dominian (1976) interprets the hostility displayed by the bereaved woman as displaced anger, which she is really feeling towards the dead husband who has abandoned her. It is not easy to direct this anger towards the husband but it can be used against others. Questions like "Why did this have to happen to me?" and asked directly of the dead husband, "Why did you do this to me?" are indicative of anger at being abandoned.

In the Glick et al (1974) study however, 20 per cent of widows interviewed expressed feelings of anger towards the husband who was seen to have contributed to his own death in some way.

When grief is viewed as a biologically adaptive reaction though, a different approach is necessary to describe the subjective reactions of the widow. Averill (1968) offers such an explanation. He says that because the grief reaction may occur in relative independence of higher mental processes the widow may not expect or understand the potency of her reaction. She therefore attempts to account for the torment she experiences by idealising her dead husband (hence making her reaction appear more

appropriate), and by adopting a position of self-condemnation and guilt for real or imagined transgressions against her husband (thus turning her grief into a punishment).

Similarly Lindemann (1944) found that the widow tends to go over the events that led up to her husband's death in an attempt to establish reasons for its happening, and often she finds evidence of her own negligence which she believes contributed to his death.

Glick et al (1974) found that widows more frequently blamed others - doctors above all - for having failed or misused their husbands.

Lindemann (1944), Wretmark (1959), Bowlby (1960a) and Parkes (1970) found that widows also often tend to be intensely preoccupied with their own future terminal illness, dying and being dead, and with fears of being alone physically and emotionally when having to face their own death. Gut (1974) feels that because of society's taboos in relation to the subject of death and dying these anxieties are the least likely to be expressed.

DEPRESSION

Averill (1968) describes the depression stage of the grief reaction thus : "Reality typically prevails, however, and, as awareness of the loss develops, a stage of despondency

and despair ensues. This is a period marked by intense mental anguish; by apathy, withdrawal, or, more rarely, compulsive overactivity; by preoccupation with the deceased and an inability to concentrate on routine tasks or to initiate new activities; and by a wide variety of somatic complaints including anorexia and other gastrointestinal disturbances, loss of weight, and an inability to sleep ...".

Parkes (1972) describes the widow's depression thus:

" She looks backwards to the past and makes no plans for the future; in a sense she may try to stop living, to arrest time." The widow experiences a sense of futility.

Parkes reports that in his studies ideas of suicide were often expressed. Many of the London widows felt for some time that they might as well be dead, but only one made a half-hearted attempt at suicide.

The work of Glick et al (1976) indicates that to have enduring feelings of purposelessness in life is common. 28 per cent of Glick et al's sample one year after their husband's death agreed that they would not care if they died tomorrow.

Glick et al (1976) report that during the depression phase of grief widows were constantly aware of their loss, as a background to their thoughts if not the focus of

them. Pervasive sadness, continued, and for some, increased sleeplessness (47 per cent at 3 weeks and 27 per cent at 8 weeks after the husband's death), increased anxiety (16 per cent), increased feelings of dependency (32 per cent) all coincide with the persisting loneliness which for most widows inevitably followed the activity and attention associated with the funeral.

65 per cent of Glick et al's (1976) sample still felt very lonely after one year. Some of the usual reactions to facing the reality of her new situation as found by Glick et al were; restlessness, especially in the evenings, which led the widow to worry about her stability; doubts about her ability to return to normal routines; fears that she would be overwhelmed by threatening feelings.

Apart from certain times of the day usually associated with the husband's presence, particular days, like Sundays, when the couple visited friends, and special days like birthdays, anniversaries, and public holidays like Christmas, were occasions for intense reminders of loss and isolation.

Gradual recognition of her loss of social status, is inevitable with the decrease in contact with what Glick et al call "couple" friends. They report that the widow is likely to retain her personal friends, but not her

membership of the social network of married friends. In the evenings when feelings of loneliness were usually greatest the widow as a partnerless woman does not qualify to be invited out in mixed company. This was also the finding of Lopata (1973). She notes the higher the social status of the husband the greater the changes in the widow's social life. Glick et al found a trend towards widows mixing only with other women in similar circumstances by the end of the first year after bereavement, with virtually no contact with males at all. This was not only the consequence of not being included by married people, but because the widows themselves did not feel comfortable in the company of couples or groups of couples. Some of the widows imagined that the wives in such groups harboured false suspicions that they were making themselves available for the husband's sexual attentions. Most widows found any notion or suggestion (usually from relatives) of emotional or sexual involvement with another man distasteful.

Parkes (1965) believes that for most widows the acute symptoms (the waves of psychological and somatic distress) are minimal after 6 months. Dominian (1976) estimates the duration of social isolation and feelings of being a social misfit at about one year.

Glick et al. (1976) found that by the end of one year most widows believed that although they had not yet achieved a

new stability, they had done well. They felt more in control of their existence, and were significantly less likely to give way to tears. Only two widows cried at the interview one year after their bereavement, as compared with one in six at two months.

RESOLUTION : A NEW IDENTITY

Parkes (1972) states that the period of depression is not a clear-cut phase, but occurs again and again in different contexts. Only when most of the roles and patterns of the previous life with her husband have been recognised as inappropriate, and the resulting disorganisation and despair have been suffered does the widow become free to establish new ways of thinking and behaving. Parkes believes this is never complete. Bowlby (1960) points out that even years after bereavement pangs of grief can be re-evoked by some small happening or memory.

Dominian (1976) states that in adult relationships which have lasted many years the memory of the dead remains a reality which survives the mourning process. An imprint is left on the survivor. This imprint becomes part of her. This phenomenon is called "identification". As Parkes (1972) points out identification of husband and wife goes on throughout married life and does not occur only after one partner dies. During early

bereavement a feeling of mutilation, often experienced and expressed in physical terms, is usual. This is countered by identification phenomena.

It can take the form of the sense of presence commonly experienced in the early stages, as mentioned earlier, or as a feeling that the husband exists "inside" the widow. This is usually felt as a warm and reassuring presence. Seeing the husband in others, often in a relative who resembles the husband physically, is another manifestation of the identification phenomenon. This can be un-nerving for the widow over long periods of time.

In general terms identification phenomena can be seen as a means of getting the lost husband back, and as a device for helping her take over the roles he has vacated. (Widows often refer back to what their husband would have done in a given set of circumstances).

Glick et al (1976) report that the first indications of recovery were usually feelings on the part of the widow that she was now beginning to feel better. Certain events were identified as turning points. An incident might provide an insight on which there was no going back; the way was now clear to begin reconstructing her life.

By the end of a year, according to Glick et al, most widows felt they were well on the way to recovery but were not yet back to being themselves totally. They had more energy, were able to be more spontaneous, and felt more hopeful about the future. They were free of grief for relatively long periods but many continued to be lonely.

Widows tended to be more confident about social situations after one year. They began to value their independence more and the advice and support of friends and relatives less. Many widows began to develop a new respect for themselves in the light of their coping with their new situation. Growing confidence helped them plan for the future.

To keep busy was seen as a good thing by 43 out of the 49 widows in the Glick et al sample. It served as a distraction, a reassurance that the widow could continue to function against strong odds, as a reason for others to admire her, and in turn as a means of boosting the widow's self respect and belief in her own recovery capacity.

In the opinion of Glick et al work was the best distraction. It also assured widows that others respected their ability to contribute, promoted feelings of accom-

plishment and independence, integrated them into a social network, provided the opportunity to escape from the house and the monotony of child care, and perhaps most important provided a setting in which to establish a new identity as distinct from her marital status.

Glick et al found evidence of conflict feelings on the part of widows concerning what is appropriate behaviour. Widows felt that people expected contrary social behaviour; on the one hand they were expected to display loyalty to the dead husband by withdrawing from social participation; and on the other hand they were supposed to be realistic about their loss, build a new life and actively seek a new husband. Which ever way they went they were not approved of by one group, being censured for showing too little grief or reprimanded for becoming too withdrawn.

Early suggestions of remarriage were found to be unwelcome and even jarring by all widows. However after two months 8 of Glick et al's 49 widows said they hoped to remarry. At the time of the follow-up between 2 and 4 years after bereavement 14 of the widows had either remarried or intended remarrying. (It is pertinent to remember that this sample were all 49 years or younger). Indications from this study are that those who remarry start moving in that direction about a year after bereavement having decided upon this course of action.

Of the remaining 33 subjects, 2 had become victims of cancer, and the rest had (a) reorganised their lives about an intimate nonmarital relationship with a man but retaining the woman's social independence, (b) reorganised their lives around close supportive relationships with one or more kin, (c) established a life independent of any very close relationships, (with the possible exception of their own children). A few widows had failed to establish a satisfactory life organisation and seemed likely to continue to lead a chaotic life.

VARIATIONS IN THE GRIEF REACTION

Averill (1968) lists variations based on analyses by Lindemann(1944) and Parkes (1965). These are:

- (1) Normal grief - as previously described.
- (2) Exaggerated grief - an abnormally prolonged grief reaction, frequently with an intensification of one or more aspects of normal grief, often with neurotic features like undue guilt and identification symptoms.
- (3) Abbreviated grief - a short-lived but genuine grief reaction due to an immediate replacement of the lost object, or to an insufficient attachment to the lost object.
- (4) Inhibited grief - a lasting inhibition of many of the

manifestations of normal grief, but with the appearance of other symptoms like somatic complaints.

- (5) Anticipatory grief - the experiencing of many symptoms of normal grief before an expected loss, with an abbreviated reaction at the time of the actual loss.
- (6) Delayed grief - normal or exaggerated grief may be delayed for extended periods, especially when the bereaved person has pressing responsibilities. An event related to the original loss may initiate a reaction eventually, while in the meantime an inhibited grief reaction may occur.

THE EFFECTS OF FOREWARNING ON RECOVERY

As outlined earlier Parkes (1972) in the Harvard Study reached the opinion that forewarning of the husband's death did influence the immediate grief reactions of the widow.

Glick et al (1976) came to believe that preparation for the husband's death influenced the eventual course of recovery, but not as a result of "anticipatory grief" in Lindemann's sense. They found that although women who had forewarning experienced grief before their husbands died, the subsequent grief reaction they experienced was no less severe in terms of sense of loss. However this group were less likely to be overwhelmed initially, in comparison with those who had no preparation time and who experienced a

more severe shock reaction.

In the Glick et al study of the 36 per cent who had been told explicitly that their husbands were dying fewer than half made any plans for their lives after the husband's death, despite the fact that most of them felt it would be a good thing to do so. Glick et al speculate that they may have felt that to do so would hasten the husband's death or indicate they wanted him to die. Or perhaps they wanted to postpone the reality of impending loss.

In terms of an enduring, strong sense of the presence of the husband a significant difference emerged from the Glick et al study. After one year 9 of the 22 forewarned widows still experienced this strong sense of presence. For the other widows this was a more short term experience, if they experienced it at all.

The adequacy and the nature of recovery were thought by Glick et al to be influenced by forewarning. 65 per cent of the forewarned group moved in the direction of remarriage as a basis of reorganising their lives, while 30 per cent reorganised on other bases, with one widow not achieving stability in her life. Those who were not forewarned provided a different picture; none remarried, 75 per cent achieved reorganisation in other ways and 23 per cent failed to move towards a stable reorganisation of their lives.

Although most of those widows who had no forewarning of their husbands' death established sexual relations of some importance, and some organised their lives around this, they did not remarry. They frequently said they were not willing to risk the trauma of another unanticipated loss, nor would they place their children at risk again. Glick et al feel that with the anticipated death of the husband the couple go through a process of gradually giving up hope together. This seems to result in a fear of the illness. But from the unexpected death situation seems to come a fear of the marriage state.

CHAPTER VI

THE MASTECTOMY EXPERIENCE

THE SIGNIFICANCE OF BREASTS

That the breast has significance beyond its milk producing function is hardly likely to be questioned. Morris (1967) believes that in biological terms breasts are primarily of sexual import and that their feeding of the young function is secondary.

Bard and Sutherland (1955) state that the development of breasts has an important role in the psychic as well as the physiological maturation of women. They believe the individual meaning of the breast is determined by cultural, physiological and psychological factors. Mead (1949) compared the cultural values placed upon breast development in a number of societies and found that the female breast had been idealised in the United States to a point where it had become the primary source of a woman's identification with the female role. Silverberg (1952) asserts that the cultural importance assigned to female breasts has resulted in the woman's sexual desirability being frequently based upon the size and shape of her breasts. These statements were made before the first publication of Playboy Magazine

in 1953 which was one of the first of many widely distributed magazines emphasising breasts in explicit photographic terms as vital to sex-appeal.

Schilder (1950) describes the image of the human body as the picture the individual has of it in his or her own mind. Physical and emotional perceptions contribute to body image in a dynamic, ongoing, and constantly changing way. Life-style, social position, success level, the esteem in which others hold one and the emotional reactions of others all contribute to body image.

It is generally believed that in time most people develop a "mature body image", or an acceptance of themselves as they are. Bard and Sutherland (1955) found that there were relatively few women for whom physical attractiveness had been the primary focus in their ability to relate to others throughout life, but for those so categorised the mastectomy experience can be devastating. They are prone to accentuated anticipatory reactions and frequently suffer intense depression afterwards. This is seen as a reaction to the disruption of a basic pattern of adaptation.

MASTECTOMY

Mastectomy is the term used to describe the surgical removal of the breast. According to the amount of malignant

involvement in surrounding tissue and lymph nodes, and the opinion of the surgeon about the most appropriate surgical intervention, surgery may include the removal of more than just the breast.

Bouchard and Owens (1976) describe radical mastectomy as the en bloc removal of the entire breast, the pectoral muscles, and all fat, fascia and adjacent tissues including the axillary lymph nodes. Radiation therapy sometimes precedes and often follows such surgery. This sometimes results in lethargy, anorexia and nausea according to the sensitivity of the individual to such treatment and, in general terms, the amount administered.

Radical mastectomy affects the arm's strength and mobility. Beeby and Broeg (1970) describe exercises to restore normal function and posture. These are usually initiated within a few days of surgery and are usually painful at least initially. Clark et al (1967) report that from a third to a half of radical mastectomy patients in New Zealand develop post operative lymphedema (the gathering of lymphatic fluid in the arm) varying from slight to noticeably severe. Appropriate exercises help to prevent or alleviate this condition.

Bouchard and Owens (1976) state that about 95 per cent of all breast cancers are first discovered by the women themselves. It is generally believed that earlier detection

could save more lives. The outcome of treatment seems to be affected by the stage of the lesion when it is discovered. According to Bard and Sutherland (1955) the most frequent initial symptom or sign of breast cancer is a lump in the breast, but it may be an axillary mass, skin dimpling, nipple retraction, nipple discharge, tenderness or painful sensation.

Based on American statistics Bouchard and Owens (1976) say there is a 5 year survival rate of 84 per cent for women who have mastectomies before it metastasizes to the lymphatics, and a 56 per cent survival when there has been regional spread.

Millard et al (1971) have offered a procedure for saving the uninvolved nipple which is temporarily grafted to the woman's thigh until it can be replaced on to a reconstructed breast at a later date. The effects of this procedure appear to be a boost to the morale of the woman, a focus of hope for regaining physical normality, and an indication of the doctor's faith in her recovery. Snyderman and Guthrie (1971) have described silicone implants as quick and as having "astounding" psychological effects despite the fact that the results are "no cosmetic triumphs".

PSYCHOEMOTIONAL ASPECTS

Reactions to mastectomy are sometimes described in nursing journals in terms of the grief process. However many such observations are not presented as studies based on any degree of scientific method. Some more detailed studies of the psychoemotional aspects of reaction to mastectomy are available but have not been conducted within the grief reaction framework.

Goldsmith and Alday (1971) report that mastectomy raises several fears in women. They are the anxiety associated with any major surgical operation, fears associated with breast loss; concern about sexual desirability, interpersonal and sexual relations, and possible dangers to marriage, and the omnipresent consideration for all mastectomy candidates; the fear of death.

Klein (1971) believes that mastectomy may assume symbolic qualities; the sudden confrontation with mortality which may evoke a strong reaction to mastectomy, and the debilitating effects of old age may be confirmed in older women.

Renneker and Cutler (1952) maintain that the woman's initial problem is that of protecting the breast and that the threat to her life is a subsequent consideration. Bard and Sutherland (1955) disagree. It is their opinion that the focus of anxiety varies within and between women.

They are reluctant to generalise.

Ervin (1973), Healey (1971), Millard et al (1971) and Snyderman and Guthrie (1971) see the predominant psychological reactions to mastectomy as a sense of mutilation and a feeling of loss of femininity. Ervin (1973) believes the emotional suffering outweighs the physical pain of the mastectomy experience.

Roberts et al (1972) report that 51 per cent of their sample of mastectomised women admitted related anxiety or depression. They concluded that there is an important psychological morbidity associated with all breast operations.

Healey (1971) lists three concerns connected with lymphoedema; self-consciousness about others noticing the enlarged arm, difficulty in fitting clothes, and changes in lifestyle and social behaviour.

Markel (1971) reports anxiety related to appearance and detection by others. Concern focuses on how to prevent "crookedness" when the woman's bras rides up on the operated side, and whether suitable bathing suits are available.

Bard and Sutherland (1955) report resentment about the restrictions the disfigurement puts on choice of clothing. Robinson (1974) reports however, that in the hotter parts of Australia a number of women have found that other people seem to take very little notice of their disfigurement if they replace high necked and sleeved garments with cooler, more revealing clothes. Bard and Sutherland (1955) saw a large number of women who were fearful of being stigmatised and were careful to keep the fact that they had had mastectomies a secret.

Klein (1971) identifies the belief that cancer is always fatal, that others will perceive the woman who has had breast cancer as an outcast or untouchable, that she is in some way responsible for the disease, as commonly held beliefs. Ignorance about the disease and treatment are often perpetuated by a lack of opportunity to ask questions of the surgeon.

Being left with only one breast after surgery for cancer is experienced with ambivalence. Leis (1971) reports that the remaining breast may be psychologically important as a badge of motherhood, a sign of femininity and a psychosexual symbol. At the same time the one remaining breast is often regarded as a questionable sexual entity, and as a constant reminder of the possible recurrence of cancer.

Bard and Sutherland (1955) report frequent difficulties around sexual relations. Some women describe themselves as half men, half women, some lose all sexual desire, and some engage in sexual relations only in the dark or wearing a blouse.

Klein (1971) observes that the woman's family is affected by her adverse reactions to mastectomy. She may be unable to resume her normal role as a consequence of feelings of now being unworthy of her former position. Relationships within the family are altered resulting in numerous emotional and behavioural repercussions.

Apart from the effects the woman's altered mood may have on her family, problems may be generated from the husband's concern about his wife's survival, by his uncertainty about how to respond to her, and by the way he copes with the situation. Withdrawal on the husband's part is often interpreted by the woman as rejection which is detrimental to her adjustment.

Bard and Sutherland (1955) found that well meaning actions on the part of the husband are easily misinterpreted by a woman who may believe that her intact body is essential to her sexual desirability and is a critical factor in the marriage. They found an occasional husband

who believed that the operation had destroyed his sexual relationship with his wife. Negative feelings inevitably bring about conflict. According to the meaning body injury and illness have for him the husband may react to the actual wound in an uncontrolled way which is not representative of his feelings for his wife. Another factor is that in his concern the husband may encourage prolonged invalidism by being overprotective.

In general terms however Bard and Sutherland (1955) believe that marital relations after the wife's mastectomy are usually contingent upon the preoperative status of the marriage. A warm supportive relationship, with good communication and sexual adjustment between partners will probably survive the mastectomy experience. Problems within the marriage will probably be accentuated by it.

COUNSELLING

A number of investigators believe there is a need for counselling. Deitz (1969) suggests that the needs of the individual woman should be followed. But in general terms counselling should include assistance with acceptance of the loss of the breast, reintegration of the self-image as worthy of love and the rewards of life, and adjustment to the possibility of cancer recurrence in the future.

Renneker and Cutler (1952) state that a method which they feel helps to facilitate acceptance of breast loss is to indoctrinate the woman before surgery that her breast is a danger to her future. This shifts the woman's thinking away from the breast being a prized possession towards viewing it as a threatening foreign body.

Klein (1971) believes that preoperative counselling should help the woman to consider what to tell her family and friends about her situation. Frankness as a means of combatting the fantasies her children might have, and adult discussion are seen as desirable models of coping.

Harrell (1972) is of the opinion that the woman should be given information about what to expect during rehabilitation, including reassurance that crying spells, sleeplessness and nightmares, and numbness in the arm are not unusual, and that breast forms, which give confidence and comfort, are available.

Group therapy after the operation is seen by Klein (1971) to be valuable in that it provides a legitimate opportunity to express concerns about the situation the woman finds herself in. Trachtenberg (1971) outlines a team approach to rehabilitation where the woman and the professionals meet on a daily class type basis

during the hospitalised period. Appropriate exercises, information about prostheses, encouragement of questioning and expressing feelings are all part of the purpose of such a group. Trachtenberg stresses that the strongest factor is the group itself and the support the women give each other.

Roberts et al (1972), Healey (1971), Akehurst (1972), Markel (1971) and Trachtenberg (1971) all support the idea of visits by a former mastectomy patient who is currently functioning and looking well. Having experienced the physical and emotional effects herself such a woman can talk to current mastectomy patients with understanding and offer encouragement. The "Reach to Recovery" programme initiated by Lasser in 1969 also employs this technique. "Recovery After Mastectomy" is the title of a rehabilitation film distributed by the American Cancer Society. Also from America is a manual written for women who have undergone mastectomy, by Lasser (1972). An Australian manual along similar lines by Robinson (1974) also exists.

ROLE OF THE SURGEON

Anstice(1970) and Snyderman (1971) are of the opinion that considering he is a constant factor in the mastectomy experience, the surgeon's role in the psychological sphere

has too often been avoided. Klein (1971) found that the surgeon is perceived as knowledgeable, skilled and god-like by the woman and her family, and asserts that he is in a position to be vitally instrumental in encouraging the woman to accept her loss. Ervin,(1973) a surgeon who has been concerned at rates and the degree of psychological morbidity in women undergoing mastectomy, has developed a counselling technique which revolves around honesty, hope and the involvement of the husband.

Bard and Sutherland (1955) conclude that most women do not need psychiatric help other than that implicit in a good doctor-patient relationship and warm acceptance by their families.

FEATURES OF THE REACTION TO MASTECTOMY

The observations of Bard and Sutherland (1955) are used as a basis for outlining the features of the reaction to mastectomy. Theirs is the most systematic and detailed work available and although its approach is primarily from the medical professional, patient-management viewpoint, it presents a sympathetic picture of the woman's own experience. They include observations of women referred for psychiatric counselling. By doing so their report may present accounts of more accentuated reactions than would be expected normally.

THE IMPACT OF THE CANCER DIAGNOSIS

George (1973) states that because of its widespread occurrence the existence of cancer is well known and feared. She is of the opinion that few people are surprised at being diagnosed as having cancer; rather it comes as an affirmation of their fears.

Bard and Sutherland report that anxiety of an extremely painful nature is the most prominent reaction to the discovery of "something wrong" in the breast. Such anxiety promotes some course of action which will diminish its intensity. A biased knowledge of fatal outcomes from breast cancer often contributes to a degree of fear sufficient to immobilise the woman. She may deny the existence of the symptoms, or, recognising the implications of the symptoms she may avoid seeking help. Either reaction serves to reduce her anxiety. The woman will seek a medical opinion so long as her behaviour is not disorganised by fear, or if her husband insists.

Bard and Sutherland report that all women are "shocked", "terrified", "numbed", "panicky" or "stunned" by the probable diagnosis of cancer and at the prospect of surgery. They believe that the woman's reaction to such information and to the operation itself is largely

influenced by how she perceives the doctor. What an apparently uncaring doctor says is more threatening than information from one who is prepared to spend time with the woman interpreting the need for surgery, and listening sympathetically to her fears and feelings.

The woman may exhibit various forms of anticipatory behaviour like anger, resentment, depression and anxiety, at times reaching panic proportions, which mount from the diagnosis till the day of the operation. Most women say they would prefer to have the surgery as soon as possible after diagnosis. Bard and Sutherland found that surgery is inevitably anticipated with dread and a fear of dying while under anaesthetic, as well as anxiety at being placed in a position where the woman is vulnerable to injury and has no control over events.

In an attempt to establish the primary source of anxiety Bard and Sutherland identify the fear of the "horrendous implications" of cancer, namely inevitable death. However for many women self-preservation alone is not their only concern. Mothers of young children entertain vivid fantasies of their children abandoned, motherless and unprotected.

When it is known before the operation that the whole breast will have to be removed, for some women the

prospect of the actual loss of the breast arouses fear of greater magnitude than when they contemplate dying. Bard and Sutherland feel this is because for some women self-worth and acceptability depend almost entirely upon body attractiveness. Trying to relate to others as physically incomplete and unacceptable, being held in low esteem because of her deformity, the conviction that others will feel pity or revulsion for her, being regarded as a freak by her husband and children, and being sexually rejected by her husband are common fantasies.

HOSPITAL AND SURGERY

Bard and Sutherland found the admission to hospital to be an event of significance enough to cause panic. The woman typically feels trapped and helpless in the face of imminent disaster. She may manifest this as depression, hostility, anxiety, elation, excessive cheerfulness, talkativeness or excitement. Physiological manifestations such as insomnia, increased heart rate, headaches, sweating attacks, digestive disturbances and diffuse aches and pains are common. Concurrent life events may influence the woman's anxiety level.

Volicer (1974), using the same principle as Holmes and Rahe employed with their Social Readjustment Rating Scale, asked hospital patients to rate 45 stress inducing events

related to the experience of their hospitalisations, in terms of the relative amount of adaptation required to cope with each event. A high consensus about the order of events was found between patients, and a .88 correlation to non-hospitalised respondents was also established. 4 out of the top ranking events clearly apply to hospitalisation for mastectomy.

Bard and Sutherland observed that regaining consciousness from anaesthesia is accompanied by reactions such as feelings of relief that the operation is over and of being lucky to have survived. At this stage the woman may try to establish whether or not her breast has been removed. Many women are not aware of their breast loss for a number of days. This is seen as a defense manoeuvre, or an effort to block conscious awareness of unconscious but unacceptable knowledge.

Realisation that the breast is gone is invariably followed by depression according to Bard and Sutherland. Guilt feelings, resentment and self-depreciation may follow or combine with this. Anxiety and tension continue after the operation with disturbed eating and sleeping patterns. Some women display exhillaration, disturbing dreams are often remembered, increased dependence is commonly evident in demands for attention, expressions of anger and resentment towards family and hospital staff,

and behaviours in the form of overactivity, lethargy, withdrawal and weeping are common.

DISCHARGE FROM HOSPITAL

Many women believe their home setting and the warmth and support of their families will hasten their recovery in a way the impersonal and symbolically mutilating hospital environment cannot. However Bard and Sutherland found that for some women the prospect of leaving the hospital evokes marked apprehension in the form of being unable to "face people yet". They interpret this as indicating an expectation of unacceptability, and of feelings of lowered self-esteem. Some women believe themselves to be acceptable only to those professionals who are accustomed to mutilated and ill people. Some women elect to go to friends or relatives even when adequate care and rest are available in their own homes. Bard and Sutherland interpret this as a means to avoid the functions normally expected of them, or to avoid their neighbours. Although normally quite fit by the time they leave hospital many women stay in bed for the first two days at home. After a week most women have resumed light housework.

The fact that some women feel a need for a long period of convalescence is seen by Bard and Sutherland, to indicate

the extent to which the woman perceives her injury. On the other hand a very short convalescence is interpreted as a denial of the injury, the disease and its implications. Bard and Sutherland observed severe depression resulting from failure to sustain attempts to deny. A common belief held by women for some time after mastectomy is that the whole body has been rendered extremely vulnerable to disease or injury. Every ache and pain is interpreted as evidence of the disease's recurrence, particularly any unusual sensations in the remaining breast, which, according to Bard and Sutherland, are common.

"Minor depressions" in the words of Bard and Sutherland, are frequent in later convalescence, evidenced as irritability, nervousness, impatience and being unpleasant to live with.

Changing dressings on the operative site was reported by Bard and Sutherland to be an occasion when the woman experiences strong feelings of "disgust, horror and self hatred", fears of further injury and of hopelessness about the future, often amounting to panicky despair. When dressings are no longer necessary the woman becomes increasingly aware of the need to realistically face living with her damaged body.

According to Bard and Sutherland "Most women state that

dressing and undressing each day constitutes a dreaded emotional crisis". When engaged in daily routines they are able to forget about it. Some women dress and bathe with a minimum of exposure, others avoid looking at the scarred area. Some with small children do not allow them to see their disfigurement for fear the children will suffer, or regard their mother as a cripple.

Roberts et al (1972) found that 36 per cent of women who had experienced mastectomy "complained" of phantom breast sensations, and that this was most common in premenopausal women.

PART TWO

CHAPTER VII

THE STUDY

AIMS, HYPOTHESES AND METHOD

AIMS :

The study aims to compare and contrast two cross-sectional surveys of the descriptive, enumerative and census type. Some data will be used to establish the presence of relationships between variables.

THE HYPOTHESES :

1. (a) The loss of a breast, or breasts and the loss of a husband through death, will be met with a similar initial grief reaction which moves from denial or avoidance, to alarm reaction, to realisation and finally to resolution.
- (b) Certain interrelated features of the normal grief reaction will be evident in both conditions. These are fear, pining and emotional pain, preoccupation with loss, increased tearfulness and other physiological and psychological symptoms of stress, a continued sense of the presence of the lost breast or husband, anger shame and guilt, a feeling of

loss of psychological intactness, a sense of mutilation of the self and reduced self esteem.

2. Forewarning of the loss will result in a less severe initial response to the actual loss, and a shorter recovery period.
3. The re-establishment of the woman's sense of worth after mastectomy is greatly influenced by the degree of acceptance and support she receives from her husband and the success with which she can resume normal appearance and functions. Certain social factors in combination with components of the widow's grief process make it more difficult for the widow to resume a full and satisfying life.

METHOD :

PILOT WORK

Pilot work of an exploratory nature was carried out in the early stages. This took the form of lengthy, unstructured discussion with a large number of people in a variety of loss situations. Gradually the items for the questionnaire evolved, at first as approximations of its present form. These were assembled, used in dummy runs on a number of female subjects, and discussed with these women who helped to eliminate a number of ambiguities from the wording, and reduce the length of the questionnaire schedule.

For certain questions a yes/no type response with qualification of duration, and detailed elaboration seemed adequate. For other items to ask the subject to express her responses to an aspect of her loss in her own words seemed enough to be able to place the responses in a small number of categories. For example : Item 2 (b) " What did you feel like when you first found out that your husband was dead? " Responses to this item fell into two specific categories.

THE QUESTIONNAIRE SCHEDULES

The questionnaire schedules for each condition were designed to cover the various interrelated aspects of the reaction in parallel form for greater convenience when analysing the data. To a great extent the items in the schedules follow the sequence of the events as they occurred.

It was intended that the questionnaire would be used in conjunction with the tape recorder. No notes were taken during the interviews. This meant that the woman could relate the sequence of events and her responses to them spontaneously without having to "answer the questions" in any particular order. A middle course between the non-directive ideal and the need to cover all aspects in the questionnaire, meant that during the spontaneous description of a certain phase the appropriate question was asked to

check or achieve elaboration or clarification. Aspects not covered by the woman were initiated by asking questions from the schedule.

RELATIONSHIP OF SCHEDULE ITEMS TO HYPOTHESES

All items are relevant to Hypothesis 1. Items 1,2,7,13 and 18 are relevant to Hypothesis 2. Items 7,9,13 and 18 are particularly relevant to Hypothesis 3.

PURPOSE OF SCHEDULE ITEMS :

The items are discussed with a view to explaining what information is sought, and the manner in which responses are to be classified.

Item 1. seeks to establish the extent of forewarning the woman had of the crisis and the use she made of it, as indicated by whether she needed or wished to discuss the fact with another person.

Item 2 (a) establishes the woman's initial reaction to the possible loss,

(b) to the actual loss, and

(c) the time it took her to consciously realise the fact of her loss.

(a) and (b) will show the frequency of those who experienced initial shock or emotional numbing, and those who were able to take the information in without numbing.

Item 3 elicits some indication of perceived threat, and realisation of loss. - Numbers who did not recall dreams and those who did will be established. Themes will be established.

Item 4 seeks the foci of consciously registered fears at various stages after the forewarning and loss.

Item 5 attempts to establish the duration of preoccupation with loss.

Item 6 seeks to establish whether women were ever afraid of the strength of their emotions to the point of losing control or contemplating suicide.

Item 7 is an attempt to gain subjective assessment of the perceived magnitude of the loss in terms of initial emotional impact and the amount of effort to adjust to the loss, in comparison with another severe life event. The rating procedure gives measures of the magnitude of the loss in relation to another life event selected by the subject. Initial ratings of the loss, the number who perceived another event as more difficult to cope with and the type of other events cited will be evaluated.

Item 8 attempts to identify the incidence and targets of anger and blame.

Item 9 establishes the proportion of women who experienced the "phantom" breast or husband phenomenon, and related aspects of identification phenomena (in widows) and rate of continued awareness of loss and the thoughts such awareness prompt (in women who have undergone mastectomy).

Item 10 seeks to establish evidence of anger or protest: the proportion of women who felt unjustly singled out for such a threatening and assaultive experience.

Item 11 attempts to identify foci of pining behaviour.

Item 12 establishes changes in frequency in weeping behaviour as an indicator of the expression of distress and the time taken to regain normalcy.

Item 13 is a check list of physiological and psychological symptoms and establishes the frequency of occurrence and length of time such symptoms persisted as indicators of stress and recovery rates. A factor which must be taken into account is that many of the mastectomy group were physically and psychologically affected by radiation treatment for about 2 months after surgery. This will influence the numbers experiencing appetite loss and weight loss at least.

Item 14 is an indicator of stress levels and the proportion of women who sought to reduce their anxiety and emotional pain with drugs.

Item 15 establishes in parts (a) and (b) the extent of feelings of uniqueness, preoccupation, separateness, magnitude of sense of loss and mental anguish. (c) relates to the adequacy of social support at the time of the crisis and subsequently. (d) (e) and (f) identifies some social factors which contribute to the diminished sense of social and self-worth and further feelings of abandonment. (g), (h) and (i) apply to the married mastectomy situation only. (h) asks for information about the husband's

capacity to cope with his own responses to the reality of his wife's breast loss. (g) and (i) establishes the proportion of women who felt (or feel) their husbands provided adequate emotional support, and changes the mastectomy has brought about in the marriage relationship. Item 16 aims to identify predominant losses and gains as perceived by the women themselves.

Item 17 attempts to identify sources of support and whether the woman is willing or needs to discuss her loss with others, after the loss.

Item 18 (Mastectomy) asks women to evaluate her prosthesis in terms of comfort and appearance and attempts to assess the role it plays in her successful adjustment.

Item 18 (Widow) seeks information about the widow's perception of remarriage, its alternatives for her and the direction of reorganisation of her life.

METHOD OF ANALYSING DATA

Each interview was tape-recorded in its entirety. From the tape-recording each subject's responses to schedule items were classified according to pre-determined categories for most items or placed in categories as they emerged, as quantified data. Detailed written records were made of material given by the subjects as explanations of events and responses to these events.

Because the order of the items in the questionnaire schedule was not adhered to, the manual recording of data was a lengthy process. However this was the price paid for the high degree of richness and spontaneity achieved in the reports.

Group data was then recorded on charts to establish the frequency of responses in each category, item by item, tables and graphs drawn up, comparisons within and between samples made and levels of statistical significance established by the use of the Chi-Squared Test.

For the purposes of illustrating commonly experienced reactions and emotions typical statements made by individual subjects are presented.

THE SUBJECTS

MASTECTOMY SAMPLE

LOCATING AND CONTACTING THE SUBJECTS

All of the women interviewed had their breast(s) removed at the Palmerston North Public Hospital (P.N.P.H.) which serves a large geographical area surrounding the city. A small number of mastectomies are performed in private

hospitals in the area but none of these is included.

Initial contact was made confidentially on the investigator's behalf by circularised letter (see Appendix 1) signed by the Deputy Medical Superintendent, through the Medical Records Department at the P.N.P.H. This letter outlined the purpose of the study and invited women to participate by agreeing to be interviewed. A stamped envelope addressed to the investigator and a card for the woman to write her name, address and telephone number on, were enclosed. If the woman wished to participate she posted this card. This was the first knowledge the investigator had of the woman's identity. On receipt of the card, the investigator contacted each woman by telephone or letter and arrange a time and date suitable to both of them.

Reminder letters (see Appendix 2) worded by the Deputy Medical Superintendent in a way so as not to put women under pressure to participate were posted two weeks after the initial letter to those who had not replied to the first contact. These also included a card and stamped, addressed envelope.

This procedure was carried out twice. The first post-out consisted of 40 circularised letters which were posted to an evenly spread range of women who had had their operations up to 13 years previously, as is seen in Table V11:1.

TABLE VII : 1MASTECTOMY SAMPLE

	<u>No. Contacted</u>	<u>No. Responses</u>	<u>Useful</u>
First Post Out : (Mast. up to 13yrs ago)	40	19	18
Reminders	21	7 <hr/> 26 (65%)	2
Second Post Out : (Mast. in last 3 yrs)	20	9	6
Reminders	11	2 <hr/> 11 (55%)	2
TOTAL NO. :	60	37 (60%)	28
Verbally invited to participate - by surgeon	2		1
Verbally invited to participate by another subject	1		1 <hr/> 2
TOTAL NUMBER INTERVIEWED			30

A yield of 19 responses meant that reminder letters were sent to 21 women, and a further 7 responses resulted from these.

The second post - out contacted all women remaining on the records at the P.N.P.H. Medical Records Department who had had mastectomies within the last 3 years, and numbered 20.

(Interviews up until the time of the second post-out indicated that women who had had the operation more recently were able to cope with the interview, and gave a more detailed quality of information.)

This brought 9 responses and the subsequent reminder letters posted to the 11 who had not replied yielded a further 2 responses.

In all a total of 60 names were sent letters and 37 replies were received.

As is shown in Table VII:1, out of an overall 60 per cent response rate, including responses to reminder letters, 3 women suffering from further illness as a consequence of a recurrence of cancer, did not wish to participate, 2 had shifted to another part of the country, one was bereaved shortly after the initial contact and did not wish to take part, one older woman refused to participate because she did not understand the purpose of the interview, and 2 women had died recently according to relatives who replied.

One woman proved to be an unsuitable subject at the interview: she was unable to pursue the subject enough to cover the areas in the questionnaire schedule.

A surgeon interested in the study invited 2 of his patients to participate. Unexpected family events prevented one from keeping the interview appointment, but the other woman was interviewed.

A subject already contacted through the hospital invited an acquaintance to participate.

It is felt that this sample is as representative as it would be possible to achieve. The fact that contact was made through the hospital, probably meant that women who would otherwise not have been known by others to have had the

operation were included and that the study was seen to be approved of by a respected person and institution and therefore carried some authority to persuade participation which may not have resulted from other means of contact.

However, by the same token, it is possible that such a source of initial contact acted against encouraging some women to take part in that the surgery and hospital associations were such that they reacted negatively to the invitation. Possibly others were suspicious of the invitation, as instanced by one woman who thought that to participate meant discontinuing her patient relationship with her surgeon and general practitioner.

It seems reasonable to assume that a further proportion of those who did not respond had shifted to other areas (given that Palmerston North has a highly transient population), were too ill to want to be involved, had died or had immediate reasons, like pending holidays.

It is probable that some of the women contacted felt unwilling or unable to discuss their mastectomy experience. During the course of the interviewing 3 women who had not coped well with their loss, 2 of whom had felt totally rejected by their husbands, were known to and referred to by 2 subjects. The sample probably under-represents this category of subject.

TABLE VII : 2NUMBER OF WOMEN WORKING AT TIME OF INTERVIEW

	<u>Works Full-time</u>	<u>Works Part-time</u>	<u>Does not go out to work</u>	<u>Total</u>
Mastectomy	4	6	20	30
Widow	5	11	14	30

TABLE VII : 3
NUMBER OF SUBJECTS IN EACH AGE GROUP AT TIME OF
MASTECTOMY AND WIDOWHOOD ON-SET

	-30	31-40	41-50	51-60	61-70	Total
Mastectomy Women		2	8	11	9	N=30
Widows	6	6	8	6	4	N=30

DESCRIPTION OF THE SAMPLE : MASTECTOMY

Of the 30 women in the sample, 13 lived in Palmerston North City. Most of the remainder lived in towns surrounding the area, up to 50 miles away, and a few in the country-side.

22 were married, 8 were widows and one was a spinster.

Ten women had dependent children at the time of the operation.

In broad terms 57 per cent of the sample could be described as middle class and 43 per cent as working class people.

Table VII : 2 shows the sample to be predominantly traditional housewives or not employed outside of the home (20 out of the 30), five holding full-time employment and eleven in part-time employment.

At the time of the interview 70 per cent of the sample were aged between 50 and 67 years and the sample ranged from 42 to 74 years of age.

Table VII : 3 shows that at the time of surgery one third of the sample were less than 50 years of age, one third were between 51 and 59 years and one third were in their 60's.

Table VII : 4 shows that for 14 subjects surgery had been performed less than 2 years prior to the interviews, 8 had lost a breast between 2 and 5 years before, (making a total of 74 per cent in the 0 to 5 year range) and the remaining 8 having their surgery between 5 and 12 years before the interview.

TABLE VII : 4

NUMBERS OF SUBJECTS - TIME SINCE MASTECTOMY AND
WIDOWHOOD ON-SET: AT TIME OF INTERVIEW

	-1yr	1-2yr	2-5yr	5-10yr	10yr+	Total
Mastectomy	8	6	8	4	4	N=30
Widows	1	1	14	8	6	N=30

The most recent operation was 2 months prior to the interview, and 6 women had had their operation within the previous 6 months.

4 women had lost both breasts with an average of 3 years between operations.

All but one of the women had their breast removed because of the presence of malignant tumours. One woman had suffered from a set of persistent symptoms which she said her surgeon told her was a recognisable pre-malignant condition.

WIDOWS SAMPLE

LOCATING AND CONTACTING THE SUBJECTS

Time factors and self-selection factors on the part of widows themselves did not allow for the matching in pairs in terms of age, number of dependent children, social class etc., of the two samples which would have been highly desirable. However, in broad terms the widows sample is comparable with the mastectomy sample. It also represents middle and working class women, employed women and women not employed outside of the home, and women with and without dependent children at the time of the event. Neither group includes women over the age of 69 at the time of the loss.

Five main sources of widows were used: through the friendship networks of friends and acquaintances (yielding 14), through an insurance agent (yielding 5), through an organisation which assists one-parent families (yielding 4), through senior citizens organisations (yielding 4) and through a club for widowed, separated, divorced and single parents (yielding 3).

Initial contact was made with 66 per cent of the sample verbally by other on the investigator's behalf. After this initial contact one third of the widows telephoned the investigator to say they were prepared to be interviewed, and for the remaining two thirds the investigator telephoned them after the intermediary person had let her know who they were.

33 per cent of the sample was initially contacted by the investigator, either in person in the case of senior citizen organisations, or by telephone from a list of names given to her by an insurance agent.

In all instances widows were told the purpose of the study, the type of information sought, the length of time the interview would take, where the interview would take place and some detail about the author.

Eight widows of less than 2 years standing were approached but only 2 were willing to participate; for one nearly 2

years had elapsed since her husband died, and for the other 3 months had elapsed. (This woman was an exception and her main motivation for participating was the marked frustration she was experiencing with various government departments which she found to be inefficient in dealing with her affairs. She did not cope well with the interview and wept throughout.)

The common reason given for not wishing to participate in the study was a reluctance to review the experience because of the intense emotions still associated with the loss; resulting in the widow's belief that she would not be able to cope with the interview.

Those helping to locate widows used their own judgement as to whom they felt could adequately cope with the interview.

Whether any sample of widows used for any study has ever been truly representative is debatable. In the Glick et al (1974) study, out of 231 widows listed as suitable, only 49 (21 per cent) were successfully interviewed.

It is possible that because the greater proportion of the sample were located through friendship networks, many widows felt confident about participating in a way they would not have if the initial request for subjects had come from a stranger or in the form of a letter.

Of those the investigator approached personally or by telephone 70 per cent agreed to participate. Such a high rate of agreement to participate can in part be accounted for by the investigator's personal approach with full explanation of her purposes, but the fact that those on the list given to her had already be selected and that she was able to mention the name of the person who gave her the list must have contributed.

It seems probable that those who agreed to take part would be more accustomed to articulating their feelings, and would not be intimidated by the idea of being interviewed by a person associated with the university. Thus it was expected that the sample would include a greater proportion of middle class women.

A deliberate effort to counter balance this disproportionate representation, readily available subjects were sought from an organisation which gives material and social support to one parent families. However the inclusion of these more working class widows also meant over-representation of younger widows with dependent children.

DESCRIPTION OF THE SAMPLE : WIDOWS

Of the 30 widows in the sample 26 lived in Palmerston North City, and the remaining 4 lived in the country area around the city.

One widow had remarried.

At the time of the husband's death over half of the widows had dependent children (as compared with one third of the mastectomy sample.)

Two thirds of the widows sample could be described as middle class and the remaining 33 per cent as working class women.

As shown in Table VII : 2, at the time of the interview a greater proportion of the widows sample went out to work; 5 in full-time employment and eleven part-time, with the remaining 14 having no paid employment outside of the home.

In terms of age at the time of the interview the widows were a younger group than the mastectomy sample, with 43 per cent aged 28 to 48 years and the remainder between 50 and 73 years.

Table VII : 3 shows that at the time of the husband's death 66 per cent were aged less than 50 years and 34 per cent between 51 and 70 years. The two youngest widows were 25 years old when their husbands died and the oldest 66 years.

Table VII : 4 shows the numbers of widows in each time period since bereavement. Only two of the widows sample fall into the category of minus 2 years since their husband's death and fourteen were widowed between 2 and 5 years prior to the interview. Of the remainder 14 were widowed more than 5 years before the interview.

THE INTERVIEWS :

To minimize differences in the way the interviews were run the investigator interviewed all of the subjects herself, individually, in their own homes, at a time and date convenient to them. With the exception of two women whom the author had met fleetingly, all of the women were unknown to her at the time of the interview. Taking into account the sensitive and emotional nature of the information being sought, up to 3.5 hours were set aside for each interview, giving adequate time for the investigator and the subject to familiarise themselves with each other. Some women preferred to commence the actual interview quickly, but others spent up to half an hour establishing some sort of relationship with the author and finding out about the purpose and progress of the study. An attempt was made to establish a trusting, empathetic, relaxed, permissive relationship with each woman. However such was the apprehension with which many of the women approached reviewing their loss

experience that it was often not until the later stages of the interview that they were able to relax. At all times a "winding down" period was allowed for so as not to leave the women in an emotionally aroused state.

On average for the mastectomy sample total contact time was shorter ranging from 1 hour to 2.75 hours with actual interview time ranging from 35 minutes to 1.5 hours, but averaging 1 hour. For the widows sample actual interview time ranged from 40 minutes to 3 hours and averaged 2 hours.

4 or 5 interviews were carried out per week for 14 weeks. For the most part the author felt that the women experienced the interview as satisfying. The author gained the impression that for some, it was the first time they had spoken about their experience of loss to anyone who wanted to hear about it. Thus for these women it was the first time they had explored their own feelings in the spoken word. Several women reported they had gained new insights and perspectives on their experience as a result of the interview.

Occasionally the author was aware of some initial expressions of defensiveness or hostility. She found that by asking the women at the beginning of the interview how they felt about the prospect of talking about their loss and by giving them the opportunity to assess the author's motives

in wanting to investigate the area, most of the initial apprehension could be alleviated. The author told all of the women that if there was any aspect of the experience that arose in the questionnaire schedule they did not wish to discuss, that was their choice and she would respect this. In only one case did a subject decide not to elaborate on certain aspects of her experience. At the same time she felt able to give adequate basic responses.

In order to retain her capacity to absorb the information disclosed and to respond fully to the situation as the interviewer, in view of her recognition that the interviews were emotionally demanding, the investigator tried to interview only one or two women per day.

With the subject's consent all but one interview was tape-recorded in its entirety. This eliminated any need for writing or regulating the speed at which the subjects gave information. Some women were at first distracted by the tape recorder, but were able to forget about it as they warmed to the task of relating their experience. Such was the level of distraction the presence of the tape-recorder brought about in one woman that we dispensed with it. She was then able to respond spontaneously.

QUESTIONNAIRE SCHEDULE FOR MASTECTOMY SAMPLE

Age

Marital Status

Number of Children

Ages of Children

Do you live alone?

Do you go out to work?

How long ago did you have your breast operation?

1. a. How long was there between the time you found the lump in your breast and your operation?
- b. Did you know before the operation that your breast would be removed?
- c. Did you have an opportunity to have a good talk to someone about your operation before it took place? Who? (friend, relative, professional counsellor etc.)
2. a. What did you feel like when you were first told that you would have to have your breast removed?
- b. What did you feel like when you first realised your breast had been removed?
- c. How long did it take you to realise the fact that you had lost your breast?

3. Have there been times when you have had more dreams or nightmares than usual?

Can you remember any of these?

4. What things did you fear when you :

- a. First discovered the lump in your breast?
- b. Were first told you may have to have your breast removed?
- c. Realised you had lost your breast?
- d. Went home after your stay in hospital?

5. Have there been times when you have found it difficult to think about anything other than your breast loss, and events surrounding your operation?

For how long?

6. a. Did you sometimes feel frightened by the things you were feeling; at the strength of your feelings?
- b. Were your feelings so strong that you sometimes wondered if you could bear it any longer?

7. Can you think of another event in your life which affected you emotionally in a similar way to your breast operation and took as much effort to get over?

How similar or different is this experience?

Where would the other event fit on this scale in terms of how you felt about it?

Where would you put your reaction to your breast loss?

Unbearable

Bearable

1 2 3 4 5 6 7 8 9

8. a. Did you ever feel angry or resentful towards the doctor who did your operation?
 - b. Do you ever think of ways in which your breast could have been saved?
 - c. Do you sometimes wonder if you are to blame for your breast loss?
-
9. a. Do you sometimes have the sensation that your breast is still there?
Did you ever have this feeling after your operation?
 - b. On average how many times a day are you consciously aware of the absence of your breast?
 - c. What are your immediate thoughts when you see your scar ; say, when you see yourself in the mirror as you are undressing?
-
10. When thinking about your breast loss do you ever think or ask "Why did this have to happen to me?"

11. What aspects of having lost a breast (breasts) do you feel most strongly about?

12. a. Since your operation have you cried more often than usual? How often?

b. How long was it before you got back to normal again?

13. Here are some symptoms you may have had since your operation. Can you remember if and when you had them, how long they lasted and if you still suffer from some of them.

a. Lack of appetite

b. Lump in the throat

c. Uneasiness or "butterflies" in the stomach

d. Loss of weight

e. Gain of weight

f. Difficulty in getting off to sleep (more so than usual before your operation)

g. Disturbed sleep, waking during the night, or early in the morning and being unable to get back to sleep (in a way not usual before your operation)

h. More headaches than usual

i. Aches and pains in your body which you don't normally have

j. Feelings of being unable to concentrate

- k. Restless feeling; unable to settle to anything
- l. Feelings of irritability, not normally present
- m. Feeling unable to make decisions

14. a. Do you smoke?

Have you smoked more cigarettes since your operation?

b. Have your alcohol drinking habits changed since your operation?

c. Did you take "nerve pills" or tranquillizers before your operation?

Do you now?

If you took them before, do you take more of these pills now?

15. a. Do you sometimes feel alone or isolated?

b. Do you feel that others cannot understand how you feel, even friends?

c. Have your friends, neighbours and relatives shown as much love and support as you have needed?

(If not) How have you coped?

d. Are you invited out as much as you were before your operation?

(If not) Why do you think this is?

e. Have some of your friends stopped having contact with you?

- f. Do you think your friends value you as much as they did before your operation?
- g. Has your husband shown as much love and support as you would have liked?
- h. How has your husband/partner responded to your breast loss?
- i. Has your relationship with your husband/partner been affected by your breast loss?

16. Do you feel that you have changed within yourself?

17. Is there anyone who really understands how you feel,
whom you have been able to talk to?

Husband, friend, relative, professional.

18. Do you find your prosthesis satisfactory?

QUESTIONNAIRE SCHEDULE FOR WIDOWS SAMPLE

Age

Marital Status

Number of children

Ages of children

Do you live alone?

Do you go out to work?

How long ago did your husband die?

1. How much warning of your husband's death did you get?

(If there was warning)

Did you have an opportunity to have a long talk to
someone about the fact that your husband was dying?

Who? (friend, relative, professional counselor etc)

2. a. What did you feel like when you first found out that
your husband was going to die?
- b. What did you feel like when you first found out
that your husband was dead?
- c. How long did it take you to realise the fact that
your husband was dead?

3. Have there been periods when you have had more dreams or
nightmares than usual? Can you remember any of these?

4. What things did you fear when you :
 - a. First found out that your husband was going to die?
 - b. Were first told that your husband was dead?
 - c. Had to face living again after the funeral?
 - d. What fears have you at present?

5. Have there been periods of time when you have found it difficult to think about anything other than your loss, and events surrounding your husband's death?
For how long?

6. a. Did you sometimes feel frightened by the things you were feeling; at the strength of your feelings?
b. Were your feelings so strong that you sometimes wondered if you could bear it any longer?

7. Can you think of another event in your life which affected you emotionally in a similar way to your husband's death and took as much effort to get over?
How similar or different is this experience?
Where would the other event fit on this scale in terms of how you felt?
Where would you put your reaction to your husband's death?

Unbearable									Bearable
1	2	3	4	5	6	7	8	9	

8. a. Do you ever feel angry or resentful towards the

- doctor(s) or others who were responsible for your husband's treatment before he died?
- b. Have you ever felt angry at someone you considered was responsible for your husband's death?
 - c. Did you ever think of ways in which your husband could have been saved?
 - d. Did you sometimes wonder if you are to blame for your husband's death?
9. Do you sometimes get the feeling that your husband is near you?
- a. If not now, did you ever have this feeling?
When?
 - b. Did you sometimes think you could hear or see him?
 - c. Do you sometimes find yourself saying something the way your husband did?
 - d. Do you sometimes deliberately do something the way he would have done it?
10. a. When thinking about your loss do you ever think or ask yourself "Why did this have to happen to me?"
- b. Do you ever ask "Why did you do this to me", as if your husband were present? or "Why did you leave me like this"
11. a. What aspects of your marriage relationship do you

most miss?

- b. At what time of the day do you miss your husband most?

12. a. Since your husband's death have you cried more often than usual?

- b. How long did it take to get back to normal again?

13. Here are some symptoms you may have had since you first found out that your husband was going to die, or since your husband died. Can you remember if, and when you had them, and how long they lasted, or if you still suffer from some of them.

When you became aware that your husband was going to die	Since your husband died
---	----------------------------------

- | | | |
|----|---|--|
| a. | Lack or appetite (unusual) | |
| b. | Lump in the throat | |
| c. | Uneasiness or "butterflies" in the stomach | |
| d. | Loss of weight | |
| e. | Gain of weight | |
| f. | Difficulty in getting off to sleep (more so than usual) | |
| g. | Disturbed sleep, waking during the night, or early in the morning and being unable to get back to sleep (in a way not usual) | |
| h. | More headaches than usual | |

- i. Aches and pains in your body (not usually felt)
 - j. Feelings of being unable to concentrate on anything
 - k. Restless feeling, unable to settle to anything
 - l. Feeling of irritability not normally present
 - m. Feeling unable to make decisions
14. a. Do you smoke? Have you smoked more cigarettes since your husband's death ?
- b. Have your alcohol drinking habits changed since your husband's death?
- c. Did you take "nerve pills" or tranquillizers before your husband's death?
- If not, do you now?
- If so, do you take more, the same number or fewer of these pills since your husband died?
15. a. Do you sometimes feel alone or isolated?
- b. Do you feel that others cannot understand how you feel? Sometimes even friends?
- c. Have your friends, neighbours and relations shown as much love and support as you need?
- d. Are you invited out as much as you were before your husband's death?
- e. Have some of your friends stopped having contact with you?
- f. Do you think your friends value you as much as they did before your husband's death?

16. Do you feel that you have changed within yourself?

17. Have you had a really good talk about your feelings since your husband's death, to someone who is interested and understands you?

Friend, relative, professional?

18. Do you think you will ever get married again?

CHAPTER VIII

RESULTS

Results are presented in the same order as the items are listed in the questionnaire schedule.

Item 1

Mastectomy

- a. How long was there between the time you found the lump in your breast and your operation?
- b. Did you know before the operation that your breast would be removed?
- c. Did you have an opportunity to have a good talk to someone about your operation before it took place? Who? (friend, relative, professional)

Widows

How much warning of your husband's death did you get? (If there was warning.)

Did you have an opportunity to have a good talk to someone about the fact that your husband was dying? Who? (friend, relative, professional.)

Table VIII : 1 shows that all but one of the mastectomy sample were given prior warning that they would possibly

Table VIII : 1

NUMBER OF SUBJECTS IN MASTECTOMY AND WIDOWS SAMPLE
WHO WERE FOREWARNED OF THEIR LOSS

	<u>None</u>	<u>Possible</u>	<u>Definite</u>	<u>Total</u>
Mastectomy	1	18	11	30
Widows	18	1	11	30

Table VIII : 2

INITIAL REACTION TO FOREWARNING AND ACTUAL EVENT
MASTECTOMY AND WIDOWS SAMPLE

<u>Reaction to :</u>	<u>Shock, Numb</u>	<u>Able to</u> take in Fact
Possible and Definite Cancer Diagnosis and Mastectomy N=30	25	5
Actual Breast Loss N=30	15	15
Forewarning of Husband's Death N=12	12	
Actual Death of Husband N=12	11	1
p = < 0.001 (Chi-Squared Test)		

or definitely lose their breast. One woman understood that only the lump was to be removed from her breast.

For seventeen of the sample of thirty women fewer than 14 days elapsed between the discovery of the lump or other cancer symptom and surgery, for eleven women 15 to 28 days elapsed between the events, for one woman 6 weeks and two women more than 3 years separated the events. These women deliberately did not seek medical advice.

Eighteen of the thirty widows had no forewarning of their husband's death and twelve were forewarned 6 weeks to 7 years prior to the event. In three cases the actual death occurred suddenly.

Twelve of the mastectomy sample discussed their pending operation in depth with friends and relatives and sixteen with their husbands. Eleven of the mastectomy sample reported they did not discuss the matter with anyone. Four out of the twelve widows who received clear warning of their husband's death did not discuss the matter with anyone, seven turned to relatives and friends, and four were able to discuss it with their husband before he died.

Item 2

Mastectomy

a. What did you feel like when you were first told that

you would have to have your breast removed?

- b. What did you feel like when you first realised your breast had been removed?
- c. How long did it take you to realise the fact that you had lost your breast?

Widow

- a. What did you feel like when you first found out that your husband was going to die?
- b. What did you feel like when you first found out that your husband was dead?
- c. How long did it take you to realise the fact that your husband was dead?

As shown in Table VIII:2, 25 of the mastectomy sample at the time of possible cancer diagnosis and forewarning of possible or definite mastectomy, and all of those widows who received forewarning of their loss experienced an initial emotional numbing or blankness where they felt unable to absorb the information. This difference is not significant. (Chi - Squared Test)

However reactions to the actual loss differed significantly with half of the mastectomy sample and all but one of the widows sample responding to their respective losses with emotional numbing. ($p = < 0.001$, Chi-Squared Test)

Within the mastectomy sample no significant difference in initial reaction to actual loss occurred between those who were told definitely they would have their breast removed and those who were told they possibly would.

The one widow who did not experience emotional numbing at the time of the actual death had had two years forewarning and she and her husband had fully discussed all aspects of his pending death and made detailed arrangements for the children's and her life after his death.

Table VIII : 3 shows that, including those who experienced no initial numbing in response to the actual loss of breast, eighteen of the mastectomy group had come to realise the fact within a few hours and twenty-seven by one week. In comparison a total of eleven widows were able to fully realise the fact of their loss almost straight away and twenty five by one week. At no stage after the immediate impact is there a significant difference in the rate at which realisation of the loss occurred between the samples. However there is a trend towards a slower realisation on the part of the widows.

It should be noted that in both samples, but particularly in the widows sample, fresh realisation of the threat and

loss continued to occur over time especially as familiar or unusual activities and events were experienced for the first time since the loss. One mastectomy subject reported having to work through a set of emotional responses and practical considerations when the swimming season came and she wanted to join in this activity. A widow reported at 11 years and long after the time when she had had painful responses to the loss of her husband, she unexpectedly came upon a pair of gardening shears which her husband used to use. This triggered off a sharp sense of anguish and a new realisation of her loss.

Item 3

Mastectomy and Widows

Have there been periods when you have had more dreams or nightmares than usual?

Can you remember any of these ?

In terms of recalled dreams and nightmares which the subjects thought to be relevant, the two samples did not differ significantly. Seven of the mastectomy sample recalled dreams identified as of a threatening nature or of realisation of their loss or status as persons who have had cancer, around or after the time of their operations. Ten widows reported dreams and nightmares.

In the mastectomy sample one woman recalled a dream she had shortly before leaving hospital, where her husband had " gone off with the young girl down the road." Another woman while still in hospital woke up in a sweat from a dream where she had seen a " great heap of arms and legs and everything else with my breast right on the top." Several women experienced dreams of realisation after several months. One, after 3 months, woke up feeling very angry from a dream which seemed to crystallise the sense of reality for her that she had cancer. She said " It was not that I had not thought about it in other ways before, but it was the first time it really hit me that it could be the end of me !"

The widows' dreams tended to be predominantly about their husbands still being alive, coming out of hospital well, and doing familiar things together. At first such dreams were experienced as disappointing when the widow awoke, but over time such dreams were felt to be a comfort. Two widows with young children reported waking from threatening dreams with fears for the safety of the children, getting out of bed to check that they were alright. Some widows feared going to sleep and dreaming. They would postpone going to bed until they were exhausted. One such woman was constantly plagued by the image of her husband as he was before he died; emaciated, and feared encountering him in dreams. Others were disappointed that they did not dream about their husbands thinking of such "contact" as a comfort and for one, a means of finalising her dealings with her husband.

Item 4Mastectomy

What things did you fear when you :

- a. First discovered the lump in your breast ?
- b. Were first told you may have to have your breast removed ?
- c. Realised you had lost your breast ?
- d. Went home after your stay in hospital ?

Widows

What things did you fear when you :

- a. First found out that your husband was going to die ?
- b. Were first told that your husband was dead ?
- c. Had to face living again after the funeral ?
- d. What fears have you at present ?

Strong conscious feelings of fear were a prominent component of reaction to both events.

Mastectomy Sample :

For all but 2 women the discovery of the lump or other cancer symptom in their breast was met with a strong fear response, the primary focus of which was the cancer rather than the possibility of having the breast removed. Fear of the anaesthetic, the actual mastectomy, and repercussions of the breast loss assumed a more prominent position as the operation time came closer.

Six of the women reported that after the first impact of the cancer diagnosis had eased, fear of the prospect and consequences of the breast loss was greater before surgery and for some time afterwards. What this group articulated as major fears were also reported to have been felt to some extent by most of the married and younger women, and half of the sample's widows. These fears constituted a horror of losing part of their bodies, and feelings of shame at the possibility of being regarded as a freak or an object of pity. A majority of women remained careful over time to avoid being detected as having only one, or no breasts.

Three women reported that as the time to return home from the hospital came closer their fear of their husbands' reaction to them mounted.

However for twenty four of the women the primary focus of their fears was the possible recurrence of the disease and death. All of those with whildren felt extreme distress at the thought of losing their children and entertained vivid fantasies of their motherless survival. They experienced a strong sense that they would not be keeping faith with their children; deserting them before they had completed their undertaking.

The pervasiveness of the fear of the disease is summed up

by one woman : " Cancer hangs over you. It hangs over you. If it came out of the blue once, it can come out of the blue again. It's always there at the back of your mind no matter how much you suppress it."

Widows Sample

In the initial phase, with the exception of 2, all the women were fearful of the reality of living without their husband. They strongly doubted if they could survive alone. This feeling usually reached a peak after the activity of the funeral was over.

All of those with dependent children also focused their fears on financial hardship the children's welfare and doubts about their ability to care for their needs alone.

Few of the older widows in the sample had real worries about financial security. However a number of them sought reassurances from lawyers and bank managers even when they knew they were well off.

Ill health, loss of independence and no-one to care for them in old age were continuing fear themes for older widows. For those who were widowed in their forties and fifties the realistic prospect of a very long and lonely widowhood caused fear.

Item 5

Mastectomy

Have there been times when you have found it difficult to think about anything other than your breast loss, and events surrounding your operation ?

For how long ?

Widows

Have there been periods of time when you have found it difficult to think about anything other than your loss, and events surrounding your husband's death ?

For how long ?

Figure VIII : 1 shows that after 6 months twenty-five of the mastectomy sample and eight of the widows sample felt they were past the worst of their preoccupation, and after one year twenty-eight of the mastectomy sample and twenty five of widows felt they were significantly less preoccupied with their loss. The significant difference between the samples at 6 months ($p = < 0.001$, Chi-Squared Test) is not apparent at one year.

All women in the mastectomy sample reported a high degree of preoccupation with their possible diagnosis and the prospect of surgery before the operation. For nine the actual operation marked the point beyond which they felt

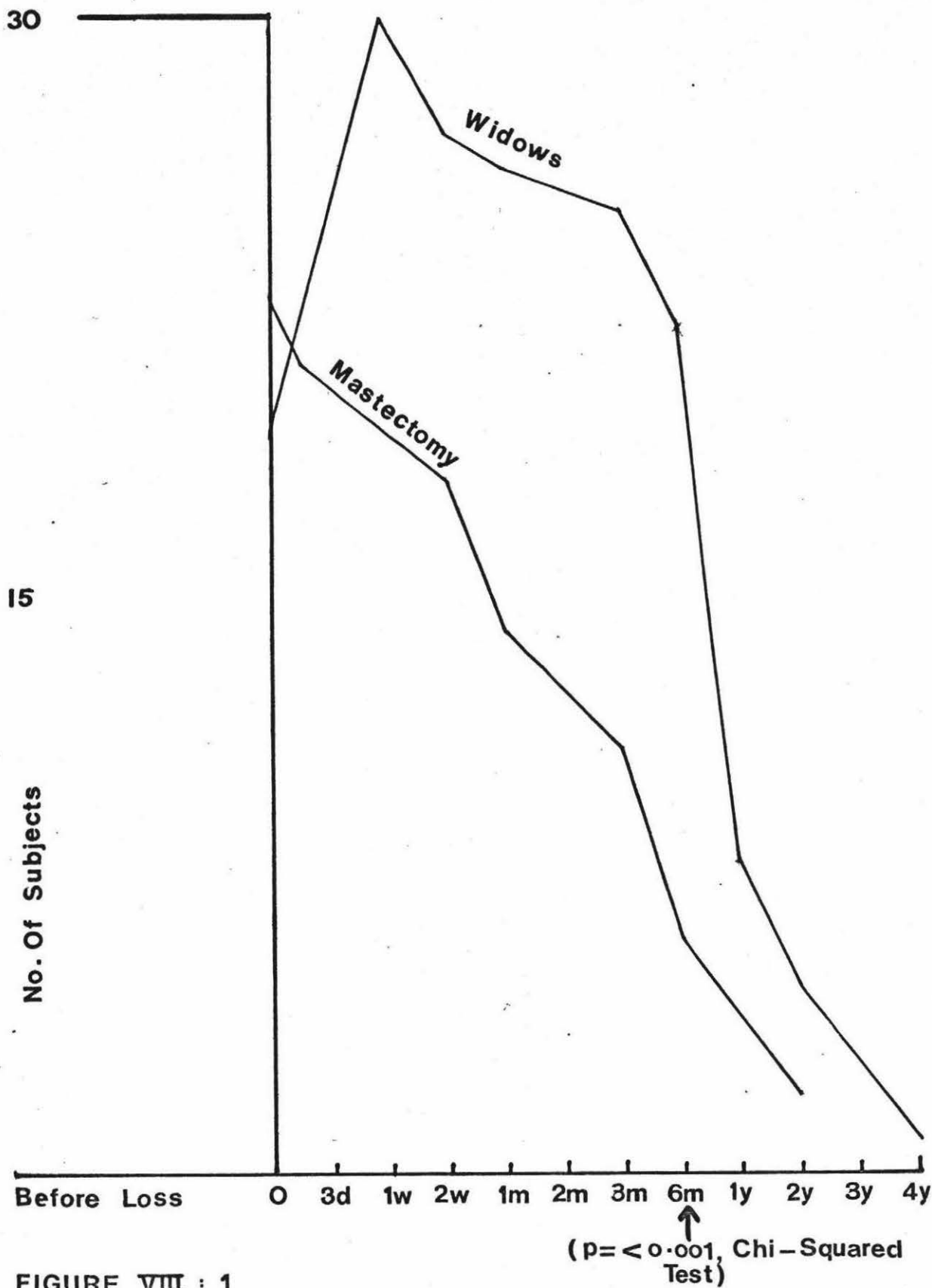


FIGURE VIII : 1

Recovery Over Time From Preoccupation With Loss: Mastectomy And Widows Samples.

able to give attention to other matters. By 2 weeks a further four were less preoccupied. This coincided with discharge from hospital for some. Two women reported a strong preoccupation with the threat to their life for nearly 2 years.

Those who experienced a second mastectomy reported equally severe reactions to the discovery of the symptom and being told the course of action to be followed, but less anxiety about the actual surgery and anesthetic. These women felt more demoralised and preoccupied with their loss after surgery, but resumed normal activities more rapidly.

Those widows who were forewarned and were aware of the fact that their husbands were dying all reported an almost complete preoccupation with the fact; the pending loss was the centre of all considerations. From their reports, in over-all terms no detectable differences were evident between the intensity and duration of preoccupation with loss of the forewarned and those whose husbands died totally unexpectedly.

Item 6

Widows and Mastectomy

- a. Did you sometimes feel frightened by the things you were feeling; at the strength of your feelings ?

- b. Were your feelings so strong that you sometimes wondered if you could bear it any longer ?

Twelve of the mastectomy sample reported they had feared losing control over their emotions and their actions at some stage during their reaction. Eleven of the widows reported similar feelings.

Five of the mastectomy sample as compared with ten of widows reported they had contemplated suicide. This difference is not significant using Chi-squared Test. None in either sample made any wholehearted attempt at suicide however. The nearest any got was one widow who walked slowly over a pedestrian crossing after the lights had changed in the hope that she would be knocked down. Four other momentarily contemplated taking overdoses of sleeping pills.

There was a trend towards widows feeling more inclined to contemplate death as an escape from their situations but they pointed out that their wish to die did not have an action component, but was more a feeling that it would not worry them if they were threatened with death. One woman reported that after 10 years of widowhood she still felt this way.

Item 7Mastectomy

Can you think of another event in your life which affected you emotionally in a similar way to your breast operation and took as much effort to get over?

How similar or different is this experience ?

Where would the other event fit on this scale in terms of how you felt about it ?

Where would you put your reaction to your breast loss ?

Widows

Can you think of another event in your life which affected you emotionally in a similar way to your husband's death, and took as much effort to get over?

How similar or different is this experience ?

Where would the other event fit on this scale in terms of how you felt ?

Where would you put your reaction to your husband's death?

Differences, as shown in Table VIII : 4 between the number who rated mastectomy and widowhood at the extreme of the unbearable end of the scale (1), and between the number who rated the events at the more bearable end of the scale (6,7, 8,9) were significant at a greater than 0.001 level using the Chi - Squared Test.

Table VIII : 4

RATING OF OWN REACTION TO MASTECTOMY AND WIDOWHOOD
EXPERIENCE ON 9 POINT SCALE : EMOTIONAL IMPACT AND
RECOVERY EFFORT INVOLVED.

		Unbearable					Bearable			
		1	2	3	4	5	6	7	8	9
Mastectomy:										
	Frequency	4	0	1	1	4	4	4	4	8
	Percentage	13%					67%			
Widows:										
	Frequency	23	0	1	1	3	0	0	1	1
	Percentage	77%					7%			
		$p = < 0.001$					$p = < 0.001$			
		(Chi - Squared Test)					(Chi - Squared Test)			

Mastectomy and Other Life Event (See Appendix 3)

When comparing the mastectomy experience with another life event: 3 women could think of no event in their lives more difficult to cope with, 3 women equated it with the death of their husband within 5 years prior to the operation, in all cases with ratings of 1. One woman equated it with the death of her son-in-law, both events rated 1. 16 women rated their mastectomy experience 7, 8 or 9, and compared it with events like their own near death or prolonged illness, death of husband, son, daughter, fiance, own nervous breakdown all of which they rated at 1, 2 or 3 (with two exceptions.)

22 of the mastectomy sample said there was some other life event which had been harder to bear and recover from.

Widowhood and Other Life Event

Fourteen of the widows were unable to think of any other event that they could compare their loss of husband with. For them it stood on its own. A further six widows rated their husband's death at 1 and equated it with, for one woman the subsequent loss of a de facto husband, and another with her mother's death; both events also rated at 1. Four widows rated the loss of a parent at 5 in comparison with 1 for their husband's death. Three widows felt the loss of their husband was more bearable than some other event; mother's death, death

of a neighbour, and the most markedly different rating of 9 for the loss of husband and 1 for the ending of a subsequent de facto relationship of 6 months standing, occurring 9 months after the husband's death. This appeared to be a case of delayed grief using the second break as a focus.

Item 8

Mastectomy

- a Did you ever feel angry or resentful towards the doctor who did your breast operation?
- b Do you ever think of ways in which your breast could have been saved?
- c Do you sometimes wonder if you are to blame for your breast loss?

Widows

- a Did you ever feel angry or resentful towards the doctor(s) or others who were responsible for your husband's death?
- b Have you ever felt angry at someone you considered was responsible for your husband's death?
- c Do you ever think of ways in which your husband could have been saved?
- d Do you sometimes wonder if you are to blame for your husband's death?

Mastectomy Sample

Twenty two of the mastectomy sample reported they had at no time felt anger or resentment towards their doctor, not the surgeon who had performed the operation. A common expression was " I just put my faith in the doctor. After all he knows what he is doing." Eight reported they had experienced moderate to strong feelings of anger in this direction. In the main their comments were to the effect that the surgeon showed little or no understanding of, or concern for how the woman was feeling, that he never made himself available for proper detailed discussion of the operation or the disease, and that one surgeon, as reported by four women, was inconsistent in his attitude towards them, switching between appearing very concerned before and then uncaring after the operation.

Twenty reported they accepted that breast removal was the only available effective treatment, ten felt, in a generalised way, that alternative methods of treatment should have been more fully investigated, but were not, and six felt that the surgeon had made up his mind to remove the breast without regard to what the woman felt about the matter.

Only two women felt they had any part in being responsible for the fact that they had lost a breast. They felt they

had been negligent in not being as aware as they might of early symptoms.

Widows Sample

a, b and c. Twenty one widows reported they had not felt angry or resentful towards anyone in relation to their husband's death. Nine admitted having moderate to strong feelings of this nature towards others whom they saw as having contributed to their husband's death, or as having made his life unnecessarily uncomfortable before he died. Over half of these were women whose husbands had died in hospital.

Nearly all of the widows reported that they searched initially for ways their husband's death could have been prevented. Eight continued to believe that certain identifiable factors definitely contributed to his death. One woman held her husband's mother responsible for causing the condition that he eventually died of, and several felt their husband's temperament and work habits were contributing factors.

d. Similarly, nearly all of the widows reported they had searched themselves for reasons to blame themselves for their husband's death. One woman said " You connect silly

things up. We had had a small difference of opinion about two kittens we had found. He said they would have to go or he would. Then he was found dead. It was stupid but it played on my mind for ages." 5 widows said they experienced temporary but strong feelings of responsibility for their husband's death, but for only one woman did such feelings persist beyond a few weeks. She was only just resolving her guilt 5 years later.

Essentially the two samples do not differ in these areas, except that a higher proportion of widows experienced feelings of self-blame for the event. Nor are any differences apparent within samples between the forewarned and those who had partial (in the case of mastectomy) or no warning.

Item 9

Mastectomy

- a. Do you sometimes have the sensation that your breast is still there?
- b. On average how many times a day are you consciously aware of the absence of your breast?
- c. What are your immediate thoughts when you see your scar; say, when you see yourself in the mirror as you are undressing?

Widows

Do you sometimes get the feeling that your husband is near you ?

- a. If not now, did you ever have this feeling ?
When?
- b. Did you sometimes think you could hear or see him?
- c. Do you sometimes find yourself saying something the way your husband did ?
- d. Do you sometimes deliberately do something the way he would have done it ?

As shown in Table VIII : 5, both samples reported a similar frequency of sensing the presence of the lost object. For seven widows this had a visual and audible component.

9c. Widows

One third of the widows said they sometimes recognised themselves as saying something in the same way as their husbands used to. Twenty one said they deliberately referred back in their minds to how their husbands would have approached a problem and how he would have liked something to look or be done, and acted in accordance with what they thought he would have approved of.

Two of the widows said that they had at first felt compelled to continue with the work their husbands had been engaged in, even though they did not personally wish to continue the work.

Table VIII : 5CONTINUING SENSE OF THE PRESENCE OF BREAST ANDDEAD HUSBAND

	Never	First Weeks Only	-----Continuing -----				
			2mth- 1year	1-2 yrs	2-5 yrs	5-10 yrs	10 yrs -
<u>Mastectomy</u>							
<u>Sample :</u>							
Breast	15	5	2	3	2	1	2
<u>Widows</u>							
<u>Sample :</u>							
Husband	13	5	0	1	8	1	2
9(b)							
Visual and Audible	21	7			2		

9 b. Mastectomy

Eleven women reported that although they did not like their scar they were no longer upset at the sight of it, and they fully accepted their loss. Fourteen reported they continued to be upset at the sight of their scar and at the thought of their loss. Five women in this group said they coped with these feelings by avoidance; they deliberately did not look at themselves at any time.

All of those who had dependent children at the time of the operation made the effort to allow their children to see the operative site by deliberately bathing, and dressing in their view. One woman of 50 years of age said she had never allowed her husband to see her unclothed body since the operation 5.5 years before.

With few exceptions women who had experienced mastectomy expressed some regret or disappointment about their disfigurement. One woman said " We take our intactness for granted. It's not until something like this happens that we realise how important our bodies are ." Another woman said " You feel you're losing some of your womanly charms ", another : " It is ugly. You are mutilated you know. There's no way around that." and another : " You don't feel the same after you've had the operation. You can't. You feel embarrassed about it. You feel a bit of a misfit when you are undressed. It doesn't matter how you behave outwardly;

it's just how you feel. It persists. It's inevitable.
It's something that stares you straight in the face once
you're undressed."

Item 10

Mastectomy

When thinking about your breast loss do you ever
think or ask " Why did this have to happen to me?"

Widows

- a. When thinking about your loss do you ever think or
ask " Why did this have to happen to me? "
- b. Do you ever ask :
" Why did you do this to me ?", as if your husband
were present? or
" Why did you leave me like this ?"

Eighteen of the mastectomy sample and twenty-one widows
admitted they asked " Why did this have to happen to me?"
Commonly accompanying this question were feelings of having
been singled out or being victimised by some omnipotent
force. With the mastectomy sample this protest was evident
in an evenly spread way, but in the widows sample it was the
younger widows who tended to feel most severely unjustly
treated.

One third of women in each sample reported some guilt feelings at experiencing the urge to protest in this way. One widow of 2.5 years standing continued to feel ashamed at the selfish way in which she expressed her anger and protest at the time of her husband's death.

Women in both samples tended to try to rationalise their experience, or reduce their feelings of anger at being victimised by taking the wider view of cancer, and of death, as common occurrences and asking " Well, why not me? " Both groups also used the strategy of viewing their own experience in the broader perspective of the situation of others. Women in the mastectomy sample compared the loss of a breast with losses sustained by others; arms, legs or vital organs. They frequently remarked that to lose a breast was a small sacrifice if it meant continuing to live. However only two spoke of other disabilities and diseases which they perceived as more undesirable than their own cancer.

Widows compared the way their husbands died with other ways of dying. They compared the quality of their lost relationship with that of couples they knew to be unhappily married, or separated or divorced. They compared their current financial situation with that of others. Those with adult families or no children compared themselves with those who had the burden of bringing up a family alone. Those who had young children reported they were able to continue seeing some purpose in life which they could not imagine without their child-

rearing task,

While such strategies did succeed in providing a wider perspective in which to place their experience, they sometimes rebounded. One woman who was able to rationally see that to lose a breast at a post-child-bearing age, and to have the reassurances of a supportive husband put her in a better position than some women, experienced a strong sense of guilt at continuing to feel angry and depressed at her fate.

b. Despite the fact that all of the widows with dependent children at the time of the husband's death reported they were grateful to have them as a focus of their purpose in life, all but one said that at times they had directed their protest and anger towards the dead husband with the question " Why did you do this to me?" and " Why did you leave me like this?"

Item 11

Mastectomy

What aspects of having lost a breast(s) do you feel most strongly about ?

Widows

a. What aspects of your marriage relationship do you most miss ?

b. At what time of the day do you miss your husband most?

Mastectomy Sample

Two thirds of the married group said that they felt their successful adjustment to losing a breast had been very dependent upon the continuing support and encouragement of their husbands.

50 per cent of the whole sample felt that they would have been more upset about losing a breast if they had been young when it happened.

All but one of the widows reported that they would have been more upset if they had lost their breast while they were still married.

Eight women in the sample said they felt deprived at the limitations put upon the range of clothing they could now wear, especially in the warmer weather. Two women said they still went swimming but were constantly anxious that their prosthesis would become dislodged and float away.

Ten women said they felt annoyed that people who knew they had had a mastectomy often stared in an attempt to detect which breast was missing.

Ten women in the sample said they would have liked someone who had had a mastectomy to visit them before or during their hospitalisation, to give encouragement and advice.

All but two of those who stayed at a residence available to out-of-town patients during their postoperative radiation therapy stage of treatment, said the experience was helpful in that it provided them with sympathetic company during a period when they were very preoccupied with their loss and their cancer. In such a setting they felt able to freely discuss their feelings and give support to others.

Widows Sample

Twenty - nine widows reported they missed their husband in emotional and social ways. Only one woman reported she did not miss her husband in these ways, and that although it had taken her some time to become accustomed to his permanent absence her social, emotional and financial well-being had increased since he had died.

Twenty-eight felt they most missed being known especially well by another person; to be a special person and to have a special person, and in terms of companionship; to have someone to share everyday life with.

Fourteen out of the sample who had led a fairly active

social life missed having a partner on social occasions.

All but one woman with dependent children reported missing having someone who was interested to help bring up the children and discuss their cares and activities with. Two of this group made the point that although there were rewards in having the children they inevitably needed more emotionally, than they gave and without a husband the woman herself received inadequate " emotional recharging ".

Twenty-six said they missed their husband most in the evenings while two widows said they were most acutely aware of their aloneness in the mornings when they first woke up.

Item 12

Mastectomy

- a. Since your operation have you cried more often than usual?
- b. How long was it before you got back to normal again?

Widows

- a. Since your husband's death have you cried more often than usual?
- b. How long did it take to get back to normal again?

In the mastectomy sample 3 women reported they did not cry during the whole experience. Neither did 3 of the widows. Another widow cried only once, two days after her husband's death.

10 of the mastectomy sample did not cry prior to their operation but 7 did afterwards. 6 women were more tearful before surgery and not afterwards.

Of the 12 widows who received definite prior warning of their husband's death 7 reported increased tearfulness before the actual death.

Figure VIII : 2 represents the following findings : In general terms the mastectomy sample reported a more rapid recovery rate. At 3 months after the loss eight of the mastectomy sample continued to be more tearful as against twenty three widows : a significant difference; $p = < 0.001$, using the Chi-Squared Test. After 6 months seven of the mastectomy sample as compared with seventeen widows continued to be more given to tears than normally. By 1.5 years those who remained more tearful constituted 7 per cent of the mastectomy sample and 40 per cent of widows : a significant difference ; $p = < 0.01$, Chi-Squared Test.

During the interviews one mastectomy subject cried. She had had her operation 1.75 years before, but she had also lost her husband within two weeks of the operation. Six

30 .

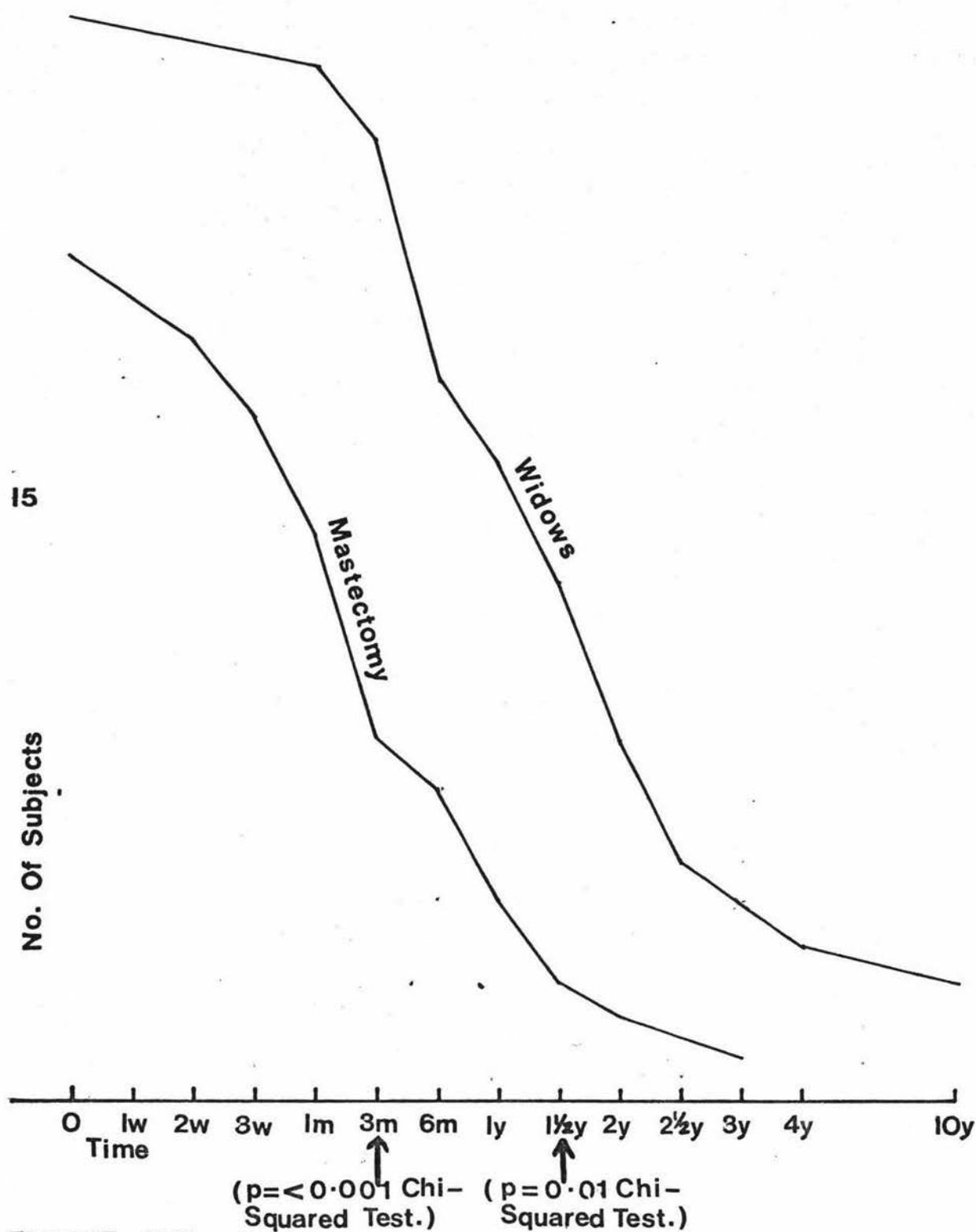


FIGURE VIII : 2

Recovery Over Time From Increased Tearfulness After Mastectomy And Husbands Death.

of the widows wept or came near to losing control at the interview. They were all of less than 2.5 years standing as widows except one whose husband had died 14 years before, but whose relationship of 4.5 years with a de facto husband had ended 8 months prior to the interview.

Item 13

Mastectomy

Here are some symptoms you may have had before and since your operation. Can you remember if and when you had them, how long they lasted, and if you still suffer from some of them?

Widows

Here are some symptoms you may have had since you first found out that your husband was going to die, or since your husband died. Can you remember if, and when you had them, and how long they lasted, or if you still suffer from some of them?

- a. Lack of appetite (unusual)
- b. Lump in the throat
- c. Uneasiness or "butterflies in the stomach"
- d. Loss of weight
- e. Gain of weight
- f. Difficulty in getting off to sleep (more so than usual)

- g. Disturbed sleep, waking during the night, or early in the morning and being unable to get back to sleep (in a way not usual)
- h. More headaches than usual
- i. Aches and pains in your body (Not usually felt)
- j. Feelings of being unable to concentrate on anything
- k. Restless feeling, unable to settle to anything
- l. Feeling or irritability not normally present
- m. Feeling unable to make decisions

Physiological and psychological symptoms of the type described by Lindemann (1944) occurred invariably in those widows who had clear forewarning of their husband's death. These were spread over such a wide time span that they are not represented in Figure VIII : 3. For the mastectomy sample however, symptoms prior to surgery have been represented, as all but one of these women were forewarned of the possibility of a cancer diagnosis and breast removal, within 28 days of the operation.

Figure VIII : 3 shows two main differences between the samples : (a) About 33 per cent of the mastectomy sample reported that their major reaction to the threat of cancer and the loss of their breast took place before the operation, and (b) a considerably larger proportion of widows reported experiencing the symptoms listed and these took significantly longer to subside.

Sub items (f) weight gain, (i) headaches and (j) aches and pains, are not included in Figure VIII : 3, as frequencies were not great enough to include accurately.

Weight gain by one year was reported by two women in the mastectomy sample, and four widows. Invariably this was caused by compensatory behaviour or comfort eating. Four of the mastectomy sample and two widows reported having headaches in the first 6 months not normally experienced.

Six of the mastectomy sample and nine of the widows reported they experienced for up to one year aches and pains not normally present. However all women in the mastectomy sample with a cancer diagnosis tended to put new significance into the aches and pains they admitted they had previously; interpreting them as signs of recurring cancer. Similarly 2 widows whose husbands had died of cancer imagined they also had cancer whenever they experienced any physical discomfort.

Sub items (a), (b) and (c) were reported as present after diagnosis and before surgery by half of the mastectomy sample. Nearly all of the sample admitted the presence, often in severe form, of these symptoms along with heart palpitations, sweating and high anxiety levels during the 24 hours before their operations, rising to panic proportions for many as the time for surgery approached. For nine women

30

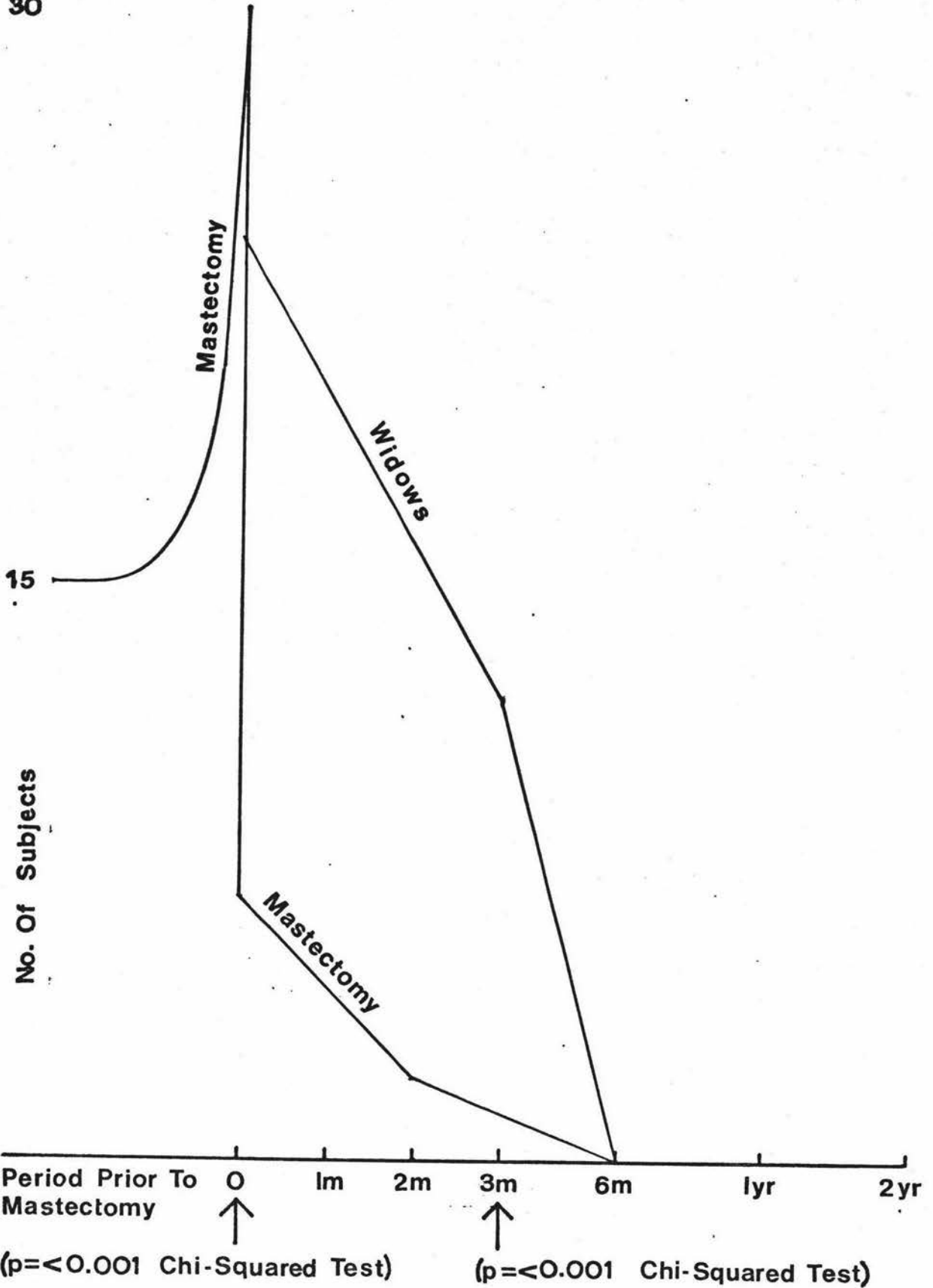
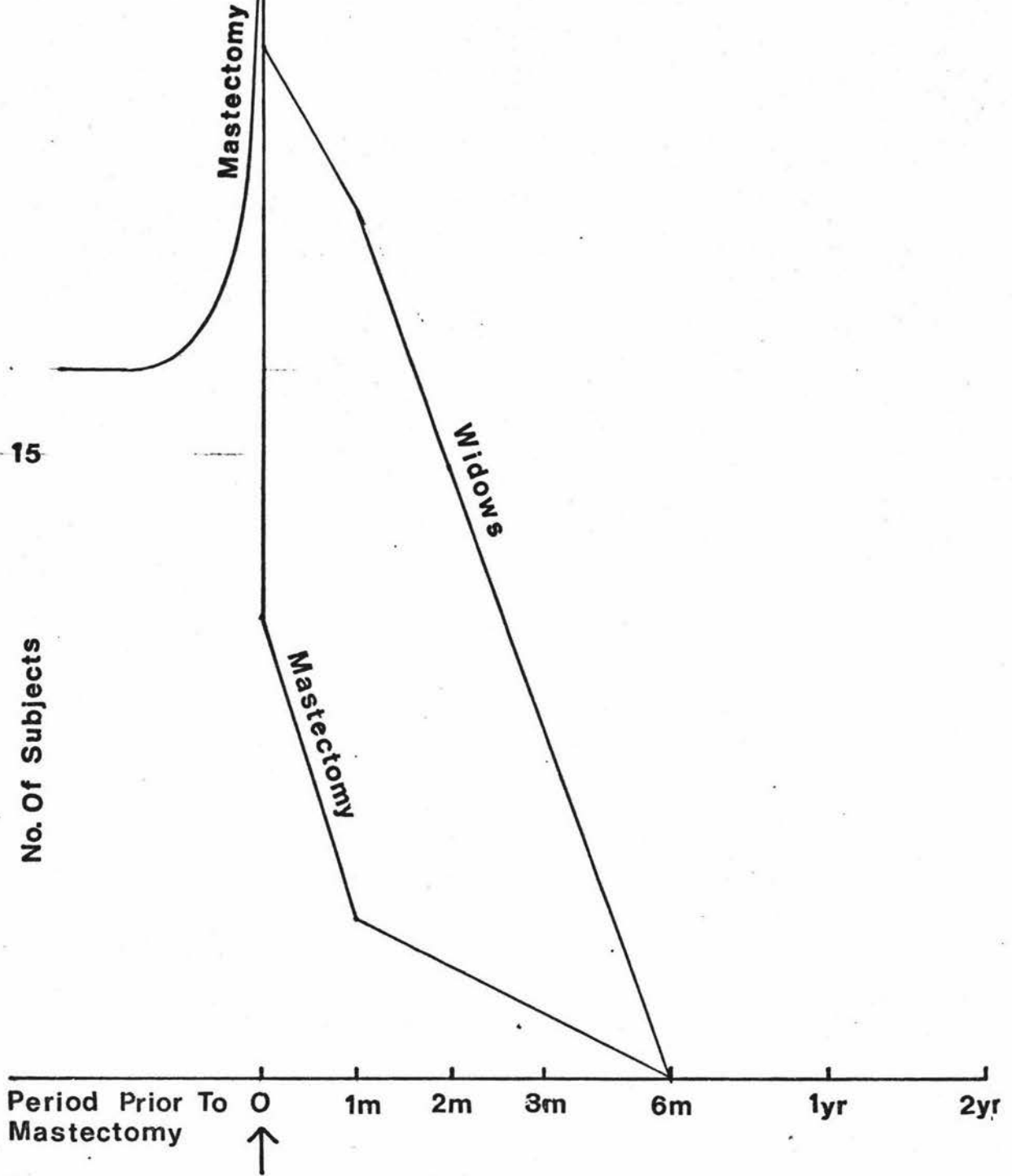


FIGURE VIII: 3 b (Item 13)

Duration of Various Physiological and Psychological Symptoms Over Time in Mastectomy and Widows Groups

3b: Lump In Throat

30



($p < 0.001$ Chi-Squared Test)

FIGURE VIII: 3c (Item 13)

Duration of Various Physiological and Psychological Symptoms Over Time in Mastectomy and Widows Groups

3c: Butterflies In Stomach

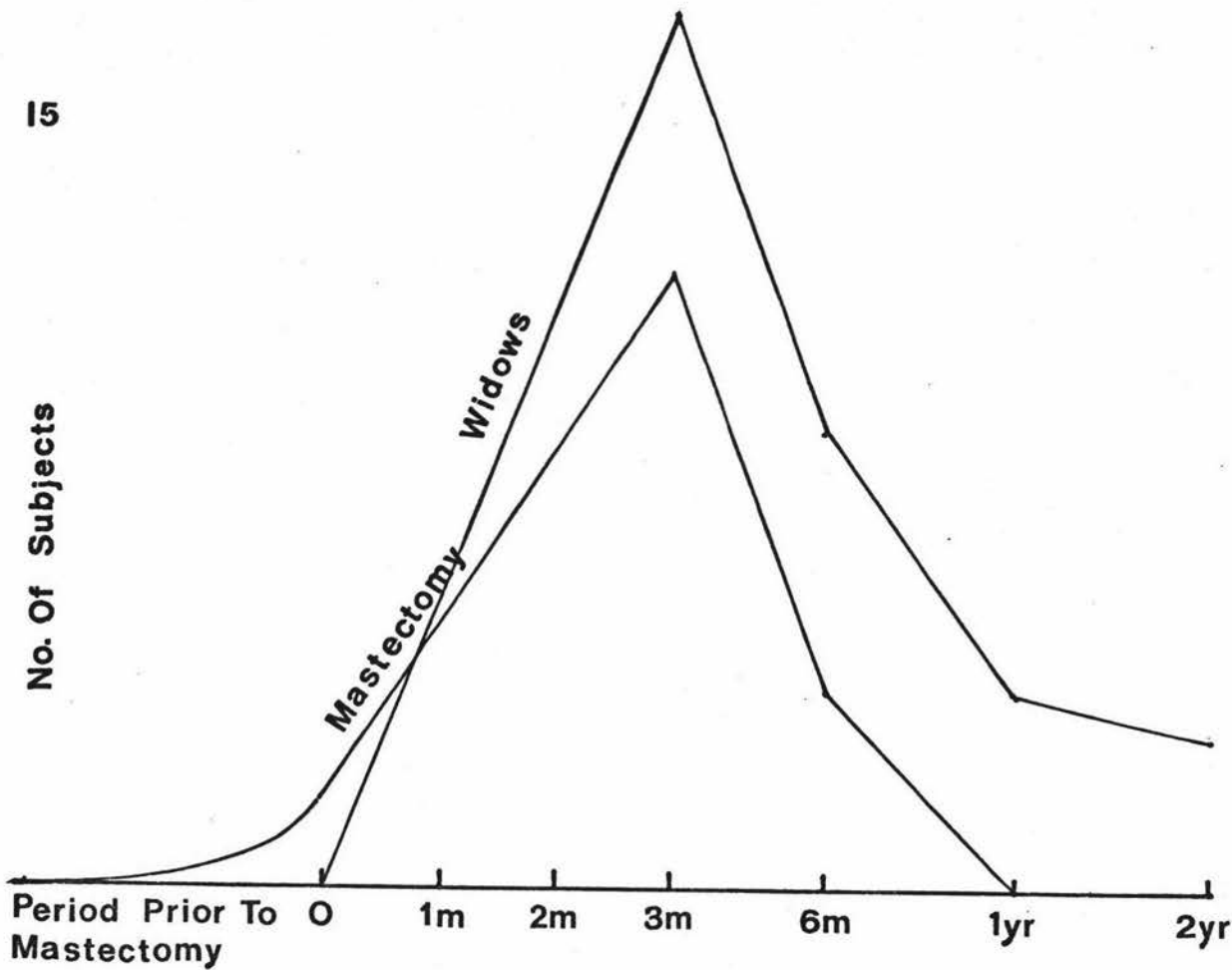


FIGURE VIII : 3 d (Item 13)
Duration of Various Physiological and Psychological Symptoms
Over Time in Mastectomy and Widows Groups
3 d : Weight Loss

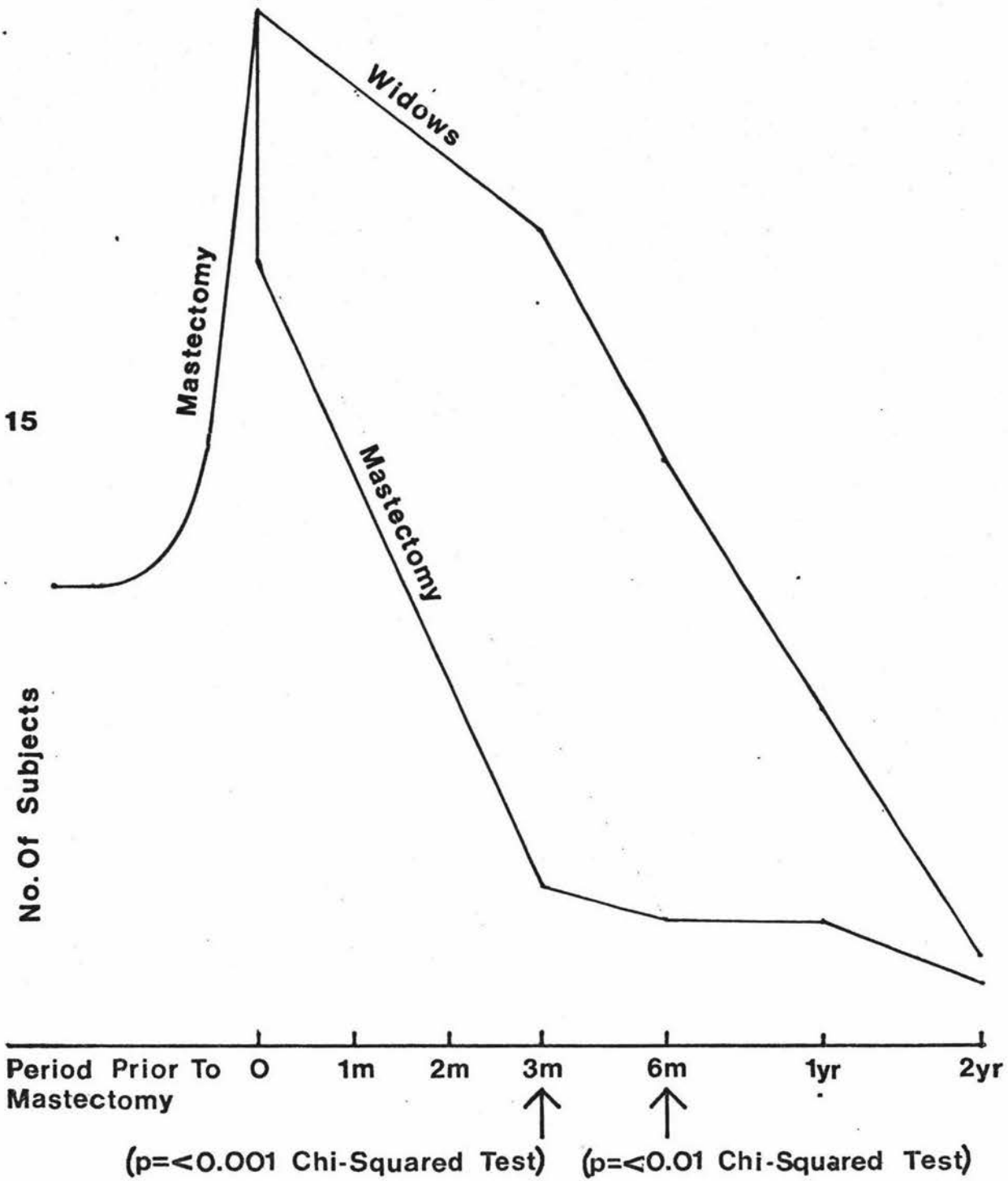


FIGURE VIII : 3f (Item 13)
Duration of Various Physiological and Psychological Symptoms
Over Time in Mastectomy and Widows Groups
3f : Difficulty Getting Off To Sleep

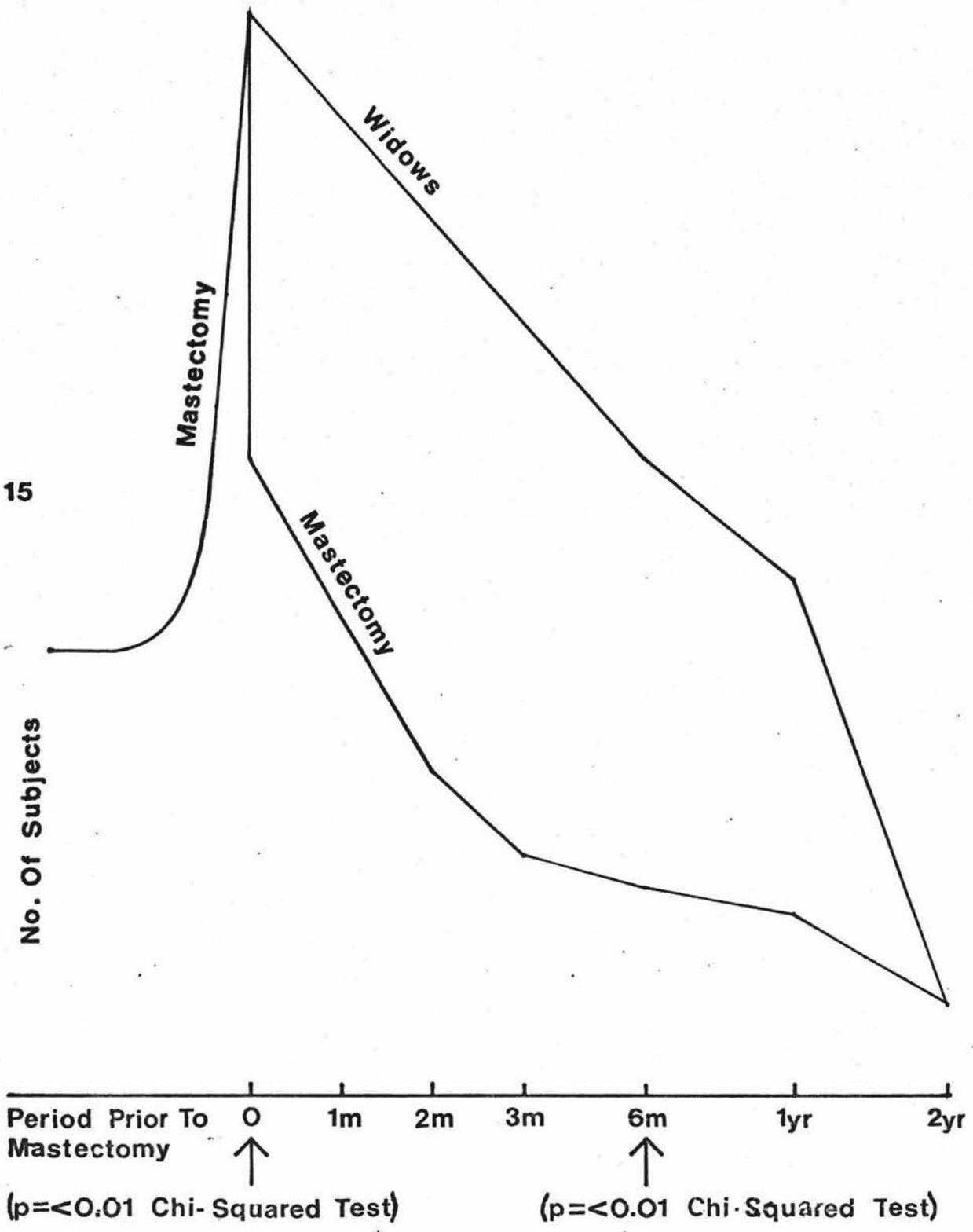


FIGURE VIII: 3g. (Item 13)
Duration of Various Physiological and Psychological Symptoms
Over Time in Mastectomy and Widows Groups
3g : Disturbed Sleep

such symptoms were almost absent after the operation, but for another nine women the postponement of facing the cancer diagnosis and breast loss was no longer possible. Their confrontation with reality was accompanied by these symptoms. Between 80 and 90 per cent of widows reported experiencing the symptoms (a), (b) and (c) at severe levels at first and in waves of diminishing intensity and frequency until at 6 months few still experienced them. A majority of widows reported that although they were able to eat again their disinterest in food persisted up to the time of the interview, in some cases 10 years later.

Sub item (d) refers to weight loss. In some of the mastectomy sample this is attributable to a reaction to radiation treatment which continued for over 2 months after surgery for some women. At 3 months a peak is reached in the frequency of loss of weight in both samples. While all but one mastectomy subject had regained or exceeded their normal weight by one year, three widows had not.

Inability to get to sleep (f) and disturbed sleep (g) were reported as being persistent symptoms by both samples, but more severe and enduring for the widows sample and predominantly the widows in the mastectomy sample.

A lack of concentration and feelings of restlessness were reported as occurring in statistically different frequencies

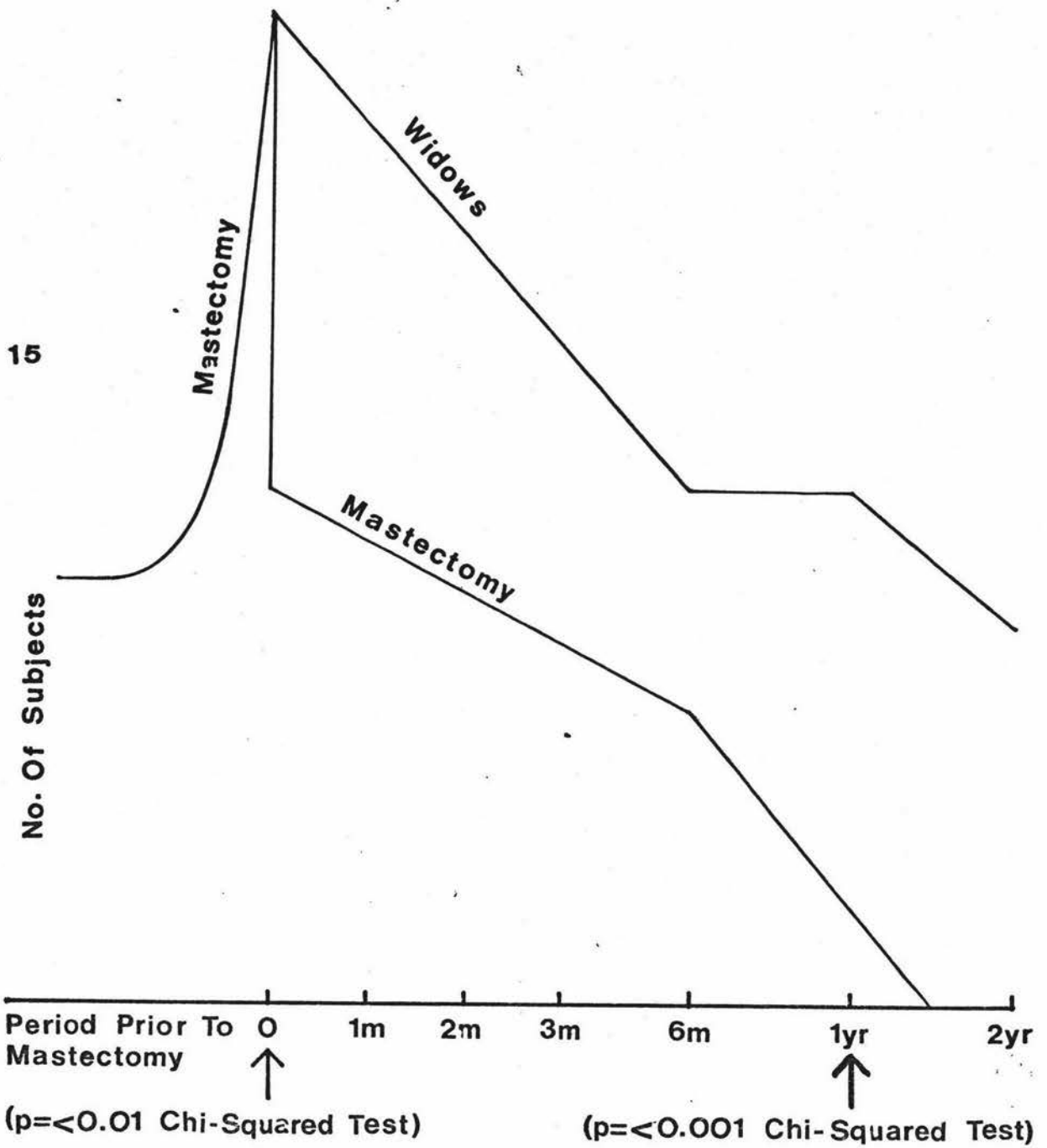


FIGURE VIII : 3i (Item 13)
Duration of Various Physiological and Psychological Symptoms
Over Time in Mastectomy and Widows Groups
3j : Lack Of Concentration

30

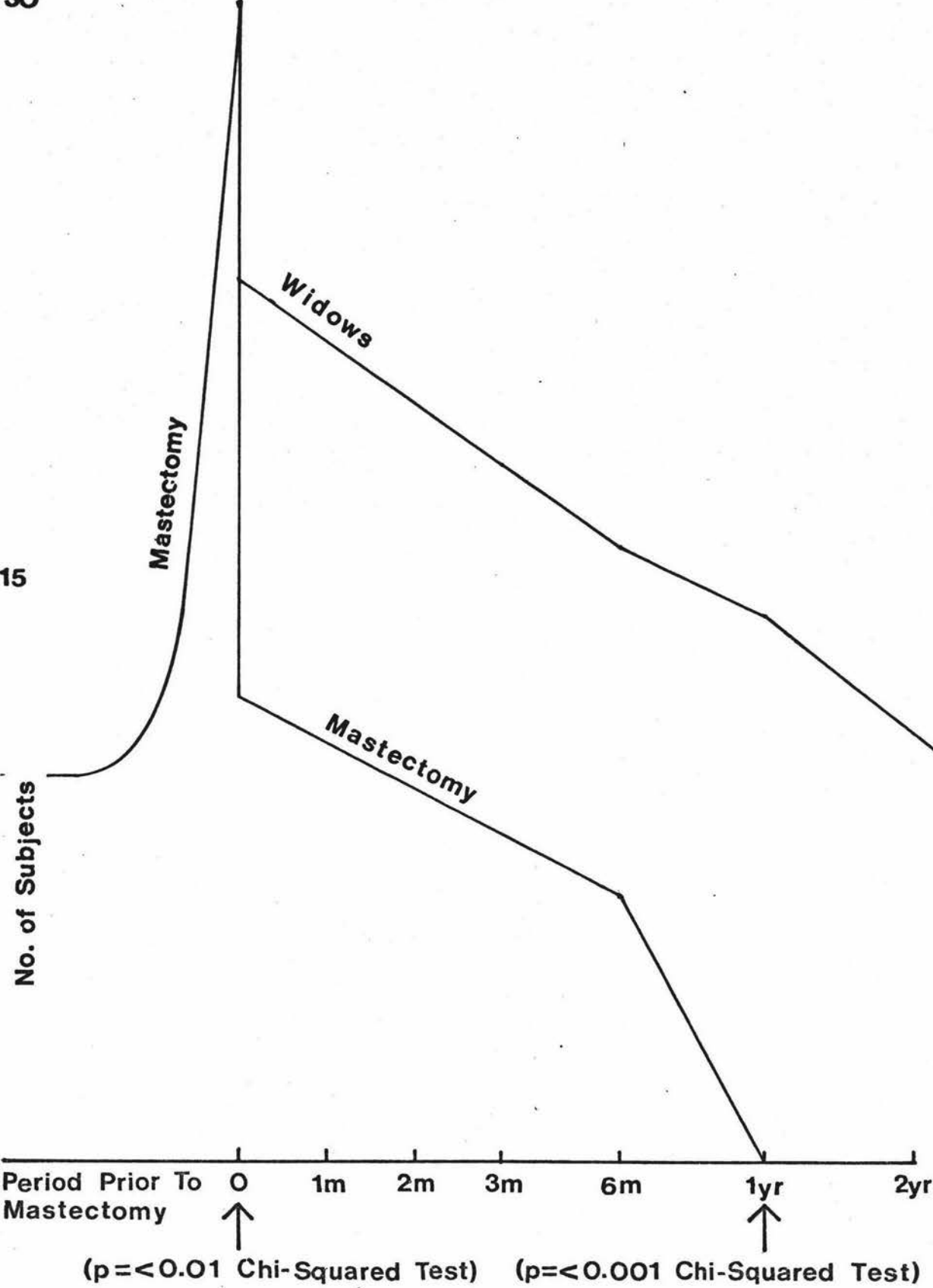


FIGURE VIII: 3k (Item 13)
Duration of Various Physiological and Psychological Symptoms
Over Time in Mastectomy and Widows Groups
3k: Restlessness

30

15

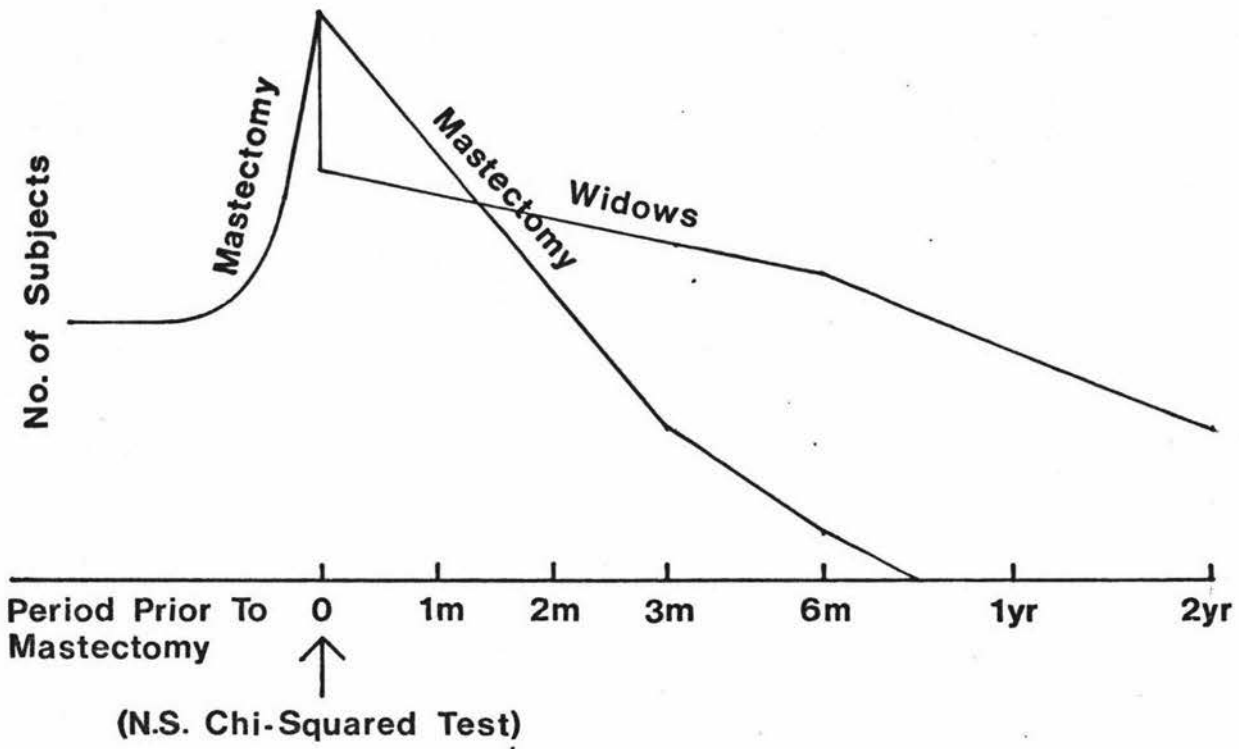


FIGURE VIII: 3 I. (Item 13)
Duration of Various Physiological and Psychological Symptoms
Over Time in Mastectomy and Widows Groups
3 I.: Irritability

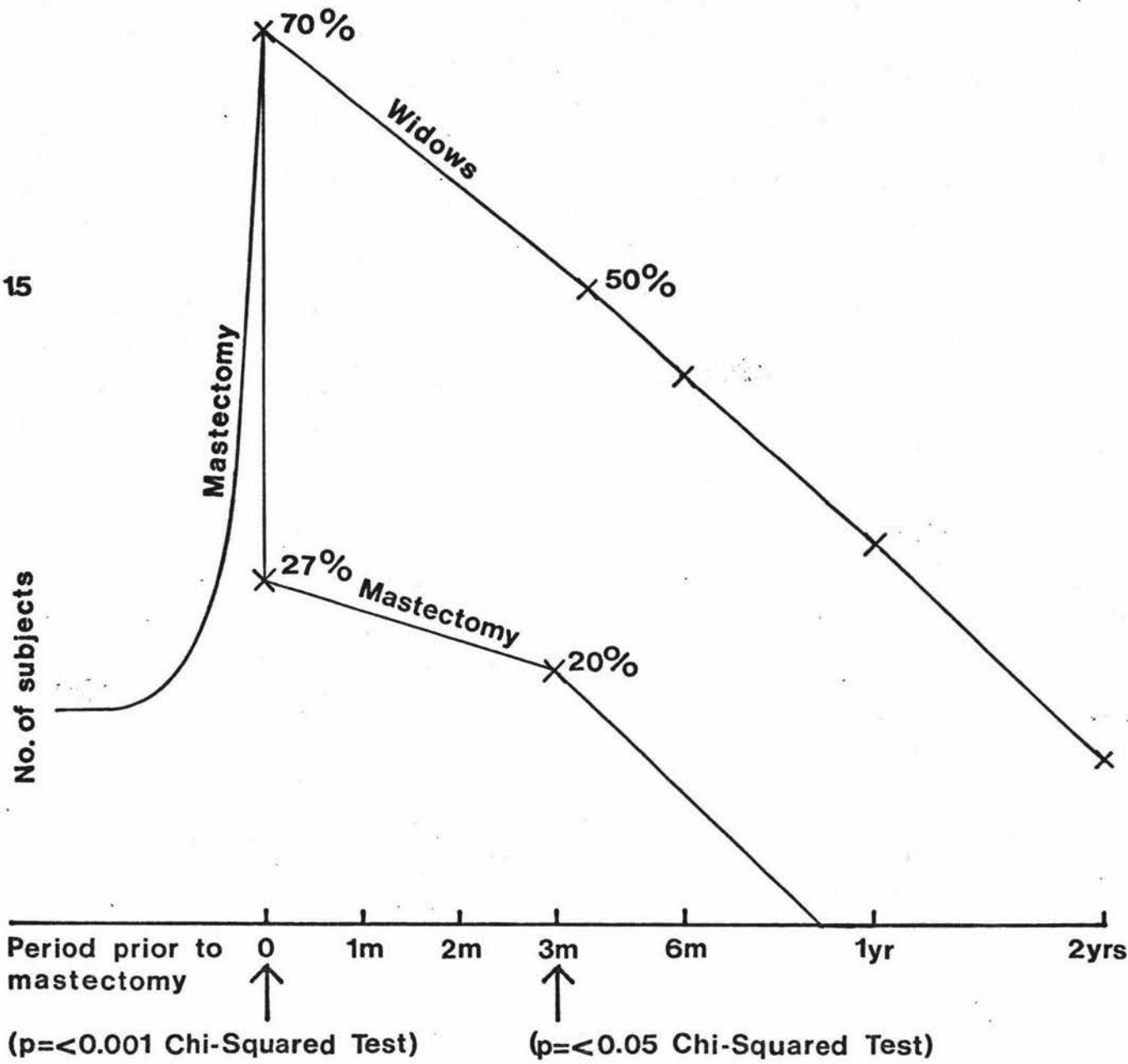


FIGURE VIII : 3m (Item 13)
Duration of Various Physiological and Psychological Symptoms
Over Time in Mastectomy and Widows Groups
3m: Inability To Make Decisions

(a) immediately after the respective losses ($p = < 0.01$ Chi-Squared Test) and (b) at one year ($p = < 0.001$ Chi-Squared Test), as shown in Figures 3j and k.

Again the widows in the mastectomy sample reported that they continued to have these symptoms.

More (but not significantly so) mastectomy subjects admitted initial increased irritability (1) than widows. By 6 months one woman in the mastectomy sample, as compared with six widows said they were more irritable. (Figure 3 l)

In terms of inability to make decisions widows were significantly more affected ($p = < 0.001$ Chi-Squared Test) at time of loss, and for longer, as shown in Figure 3 m.

Item 14

Mastectomy

- a. Do you smoke ?
Have you smoked more cigarettes since your operation?
- b. Have your alcohol drinking habits changed since your operation ?
- c. Did you take "nerve pills" or tranquillizers before your operation ?
If not do you now ?
If so, do you take more, the same number, or fewer of these pills since your operation ?

Widows

- a. Do you smoke ?
Have you smoked more cigarettes since your husband's death ?
- b. Have your alcohol drinking habits changed since your husband's death ?
- c. Did you take "nerve pills" or tranquillizers before your husband's death ?
If not, do you now ?
If so, do you take more, the same number or fewer of these pills since your husband died ?

Table VIII : 6 shows little difference in changes in smoking patterns between samples. 2 women in the mastectomy sample and one widow whose husband died of cancer, gave up smoking at a time when many smokers tended to increase their consumption.

(b) Seven widows reported significant increases in alcohol consumption over periods of a few weeks to 3 years. None of the mastectomy sample reported any increase in consumption.
($p = < 0.01$, Chi-Squared Test)

The pattern of pharmacological drug consumption was essentially the same for both samples. (Table VIII : 7)

While in hospital and under the care of their doctor afterwards 50 per cent of the mastectomy sample were introduced to

Table VIII : 7

FREQUENCY OF USE OF SEDATIVES, TRANQUILLIZERS
AND HYPNOTICS AFTER MASTECTOMY AND HUSBAND'S

DEATH

	<u>No Drugs</u> <u>Before or</u> <u>After Loss</u>	<u>No Drugs</u> <u>Before, Took</u> <u>Drugs After</u>	<u>Took Drugs</u> <u>Before and</u> <u>Continued</u>	<u>None Before</u> <u>Continued</u> <u>After</u>
Mastectomy	14	15	1	6
Widows	13	13	1	4

these drugs. Six continued to use them on a reported "occasional basis" and one used sleeping tablets every night.

Widows were more inclined to want to face their loss without drugs. 4 widows were given tranquillizers or sleeping tablets but took only 2 or 3 of them because they did not like the effects they had upon them. 5 widows took such drugs for one to two weeks, and 4 widows took them for up to six months. One widow reported that she felt that the tranquillizers she took for three months impeded her realisation process and prolonged her grief. Another said she felt she could not have survived the first six weeks if she had not had tranquillizers.

Item 15

Mastectomy

- a. Do you sometimes feel alone or isolated ?
- b. Do you feel that others cannot understand how you feel, even friends ?
- c. Have your friends, neighbours and relatives shown as much love and support as you have needed ?
(If not) How have you coped ?
- d. Are you invited out as much as you were before your operation ?
(If not) Why do you think this is ?

- e. Have some of your friends stopped having contact with you ?
- f. Do you think your friends value you as much as they did before your operation ?
- g. Has your husband shown as much love and support as you would have liked ?
- h. How has your husband / partner responded to your breast loss ?
- i. Has your relationship with your husband / partner been affected by your breast loss ?

Widows

- a. Do you sometimes feel alone or isolated ?
- b. Do you feel that others cannot understand how you feel ? Sometimes even friends ?
- c. Have your friends, neighbours and relations shown as much love and support as you need ?
- d. Are you invited out as much as you were before your husband's death ?
- e. Have some of your friends stopped having contact with you?
- f. Do you think your friends value you as much as they did before your husband's death ?

Table VIII : 8 indicates the levels of statistical difference between the two samples in all perceived responses but one.

The greatest differences between samples occur in terms of

Table VIII : 8PERCENTAGES OF MASTECTOMY AND WIDOWS SAMPLESPERCEIVING SOCIAL AND EMOTIONAL REACTIONS IN OTHERS

	Mastectomy	Widows	
			(Chi - Squared Test)
a. Felt alone isolated	10	22	p = < 0.05
b. Others cannot understand	12	23	p = < 0.01
c. Enough support at time of crisis	28	24	N.S.
d. Invited out as much	30	12	p = < 0.001
e. Some friends stopped having contact	3	22	p = < 0.001
f. Personal friends value as much	29	22	p = < 0.01

social continuity : (d) and (e). Widows reported that they received fewer invitations to social functions, and that persons they had regarded as friends frequently rapidly discontinued social contact. This was particularly the case with the younger widows; 75 per cent of widows aged less than 45 years at the time of their husband's death felt this very strongly. One woman summed up the general theme surrounding this aspect : "For a while the women would come to see me in the daytime, but in the evenings when I would most have liked company no one came. Couples didn't come; only the women. People, especially women, are not very charitable. A woman on her own is a threat, especially a younger woman. They didn't want their husbands to feel sorry for you. I wasn't invited to any mixed social occasion until I found a partner." However many of the widows admitted this was not the whole story. They reported that they could see, in retrospect, that their withdrawnness, hostility and feelings of incompleteness did not encourage others to include them socially. Many widows said they felt uncomfortable in the company of people in couples and offended when they were "coupled up" with a man to keep the numbers even. As one widow put it "There was no pleasing me. If people included me I felt they were doing so out of obligation and I felt uncomfortable. If they didn't include me I was hurt and felt left out."

Most of this group said they had to start again socially on their own behalf. For many this was a difficult task. One

widow said she could not cope with visitors, but realised that part of becoming a social person again required that she returned hospitality. The following statement is indicative of her feelings of personal and social devaluation : "I can't cope with being the hostess alone. I can't be entertaining and no-one wants to come and talk to just me."

The mastectomy experience did not have such repercussions.

3 of the mastectomy sample said they had noticed social changes. 2 of these women also were widows; one reporting that a woman she felt she knew well had suddenly stopped having contact, and the other that she was no longer invited out so often. One woman, still married, said her neighbour has avoided her for the 10 months since her mastectomy. The spinster in the sample feared she would be stigmatised because she had cancer so she made sure that no one apart from one close friend knew about her mastectomy.

Sub items (a) and (b) were found to be experienced at different rates by the two samples.

Twenty-two widows felt they existed apart from the rest of the world from periods from a few weeks, up to 3 years in some instances. Some widows emphasized that it was from all other people they felt this distance, isolation or remoteness.

One woman likened it to living in a fog where she was not very aware of other people, and the days would go on one after the other, each one seeming quite long. She made no plans and lived in her own world.

Another woman likened her isolation to being tucked away behind a blind where every thing said or thought was related to her husband rather than out to those whom she spoke. She said she had the strange sense of living her life backwards, going back over the 10 years of her marriage, analysing every thought or event in a new and significant way.

Similarly twenty-three widows felt that others could not understand how they felt. In comparison ten of the mastectomy sample reported feelings of isolation and twelve felt that others were not able to understand how they felt. Some said they reviewed their life and relationships with others in the new light of being a person who may not have a very long life ahead. Others said the intensity of shock and the emotional anguish they felt caused them to believe that no-one else could possibly understand what they were experiencing. However for a majority of the mastectomy group the support they received reassured them that others did understand something of the way they felt. As was the case with the widows group, particularly the older widows, their response to their loss became an experience of enlightenment; that they could now understand how others had felt in similar circumstances.

The difference between samples in terms of the adequacy of available support (c) at the time of the loss was not significant. Widows tended to feel let down by the dead husband's family, while two of the mastectomy subjects felt they had not been given enough information and support by hospital staff (one was a widow, and the other had an unsympathetic husband.)

In the main both samples were pleased, and in some mastectomy cases, surprised at the attention and encouragement they received. It was the widows who felt that they were deserted later on, and were expected to cope by themselves before they were ready to do so.

A significant difference occurred between samples ($p = < 0.01$, Chi-Squared Test), in respect to being valued as much by personal friends (f). For the widows sample it was in the younger age group where personal friends were married that such feelings were most often found.

Item 15 (g), (h) and (i)

Mastectomy Sample Only

Sub items (g) and (h) : All but one of the married mastectomy sample reported their husbands had provided as much love and support as could reasonably be expected. Four said that despite this they did not think their husbands had really understood how they felt about their loss. One woman reported that her husband had not been supportive.

All but two reported that their husbands had coped well with their own responses to the actual physical absence of breast and disfigurement. 5 women said their husbands were visibly shocked by the initial view of the operative site, but none of these were negatively affected for long. Two thirds of the married sample said their husbands were "absolutely marvellous" or something similar.

Sub item (i) : Half of the married subjects reported that they felt their relationship, including the sexual component, was the same, and twelve reported the event had brought the couple closer in that they were now more demonstrative of feelings of love and affection. 2 women in their early 50's reported a deterioration in their emotional and sexual relationship; one where the husband had become distant and apparently uncaring, and the other where the woman said she had "drawn away" from her husband causing their physical sexual relationship to end. This woman had never allowed her husband to see her unclothed body.

Item 16

Mastectomy and Widows

Do you feel that you have changed within
yourself?

Mastectomy Sample

With the exception of those who had previously experienced

a life threatening illness or a major personal loss, all of the women in the mastectomy sample reported that their own confrontation with the threat of cancer and the loss of a breast had given them an insight into an aspect of life they had not previously understood or felt confident to support others through. In general terms the experience had provided a new basis upon which to assess the difficulties of others. This meant that the women felt more able to understand others, but also that they adopted a more clear cut attitude towards other people's problems some of which seemed insignificant and trivial now.

As shown in Table VIII: 9, nearly half of the women felt they were basically the same. Over half of the women felt they had changed. 20 per cent felt that a pervasive change in attitude towards life had occurred, mainly in the nature of a conscious decision to live each day as fully as possible, exercising more choice over what to do and with whom (more assertive and selfish), a greater orientation towards the present rather than the future, and a heightened sense of the significance of their relationship with those close to them, like family. One woman said " I decided I never wanted to shift from the street we live in and the good neighbours we have. I might not have long to live. I will enjoy my family, I will enjoy myself and I will never rush again. I will live each day as it comes, fully. " In

Table VIII : 9

PREDOMINANT FEELINGS ABOUT SELF, PERSONAL
DEVELOPMENT, AND THE CHANGES BROUGHT ABOUT BY
MASTECTOMY AND WIDOWHOOD

	<u>Not</u> <u>Changed</u>	<u>----- Felt Significant Changes -----</u>		
		<u>Losses</u> <u>Predominate</u>	<u>Gains</u> <u>Predominate</u>	<u>Different Out-</u> <u>Look & Lifestyle</u>
Mastectomy	14	5	5	6
Widowhood	6	5	16	3
	$p = < 0.05$	$p = < 0.01$		
	(Chi - Squared Test)	(Chi - Squared Test)		

similar vein another woman said " I regard every day of every year as a bonus over and above what I feared, and I make the very best of that time. "

Table VIII: 9 shows that six widows did not consider they had changed; a significant difference between samples. Three of these subjects were widows of more than 10 year's standing and were re-established in all ways, one was only 3 months into her bereavement and was defensively conserving her image of herself, one saw her husband's death as another unfortunate event in a continuously misfortune-filled life, one woman had successfully survived a severe depressive episode some years before her husband died and having done so she felt more readily able to place her loss into a wider perspective of her survival through a challenging life with some very difficult hurdles.

Three widows said they felt so different that they might as well be different people. They had perceived their husbands as very important and very clever and had patterned their whole existence around them. The death of such a dominant husband necessitated establishing a totally new life style.

Over half of the widows saw themselves as having made significant personal gains described variously as "emotional growth" "increased emotional strength", "greater self knowledge", "greater confidence", "more independence" and a tendency to

"look twice" or be more calculating. While such changes were necessary for survival and were recognised as such, some women regretted the need to have had to change in these directions as they saw themselves as losing some of the qualities of softness, gentleness and femininity.

4 or the 5 widows who saw predominantly negative changes in themselves were immigrants to this country. Two were 19 years old when they married, perceived the wifely role as the only "right" one, idealised their husband and their relationship greatly. Losing a husband for 3 of this group meant a degree of financial hardship they never reasonably expected and, as middle aged women, with no vocational qualifications, which they could see no way out of.

Item 17

Mastectomy and Widows

Have you had a really good talk about your feelings since your mastectomy / husband's death, to someone who is interested and understands you ?

Friend, Relative, Professional (Husband) ?

Eleven of the mastectomy sample and thirteen widows reported they had verbally explored their feelings about their loss and sought support from friends.

Twelve of the mastectomy sample had discussed their loss with their husband only.

Twelve widows turned to relatives for support (parents, brothers, sisters, children) three of the mastectomy sample talked with relatives; all women who had also experienced mastectomy.

Four of the mastectomy sample said they had never discussed their loss in depth with anyone. Six of the widows had never discussed their loss with anyone, and some were reticent during the interview; one had been an alcoholic for some years, 3 believed that talking about the problem rarely helped anything, one expressed strongly angry feelings that society had rejected her and indicated that her marriage had been disappointing and ambiguous. Four of this group had been left with 3 or 4 dependent children and not enough money. They said they had been unwilling to let others know just how poor they were and had no real personal friends living near them at the time of their loss.

Item 18

Mastectomy

Do you find your prothesis (breast form) satisfactory?

Widows

Do you think you will ever get married again ?

Table VIII:10 shows that eighteen of the sample reported they were completely satisfied with the prosthesis they had been able to buy. All but two of these women had medium to large breasts and used oil filled breast forms with longline brassieres. The remaining two women used a foam plastic breast form.

Two women were only partially satisfied with what they had bought. One woman's oil filled prosthesis was a size too large. The other woman was dissatisfied with the granule-filled breast form. Both women resented having to pay over 30 dollars for new oil filled forms, but thought these would be satisfactory.

Those women who reported they were unable to get a satisfactory commercially made prosthesis fell into two categories: those who continued to have discomfort and pain in the scar tissue in the operative site; and those who had either very small or very large breasts.

Four women in the sample who wore their prosthesis and brassiere only when they went out, did so because of discomfort in the scar tissue. One other woman in this category had constructed her own breast form and had satisfactorily modified her brassiere. The remaining 17 per cent said oil filled prostheses were too clumsy and heavy for them and had made their own breast forms more cheaply than the alternative commercially made ones available.

Those who were unable to find a comfortable prosthesis including the women who made their own breast form, as a group, were made up of all but one of the widows, the one spinster aged 72 years, a 72 year old woman whose husband was severely incapacitated by a stroke, a 63 year old woman and a 58 year old woman, both of whom reported they were no longer sexually active.

Those who reported satisfaction with their prosthesis comprised the still married women, except for one widow. They frequently commented that their prosthesis was "very life like", "very comfortable", "no-one would know the difference : it looks and feels real to others and the wearer." For this group these aspects seemed very important.

One woman reported " A friend asked me was it worth thirty dollars? and I told her it was worth sixty dollars, or a hundred dollars to me."

Another woman said " Ms. X came to the hospital to fit me with a prosthesis. I went home looking as normal as I was when I went into hospital. While you are in hospital you realise you will go home looking lop-sided and that's the last thing you want. I left the hospital fully equipped. It's very bad for your morale not to have a prosthesis straight away. We all have a fear of appearing

Table VIII : 10MASTECTOMY SAMPLE: SATISFACTION WITH PROSTHESIS

Completely Satisfactory	Partially Satisfactory	Not Satisfactory Wear to go out	Made Own
18	2	4	6

Table VIII : 11REMARRIAGE AS SEEN BY WIDOWS SAMPLE

Unlikely, BUT: slight possib- ility	Definitely Not	De Facto Relationship or remarriage	Want to remarry	Has Remarr- ied
13	10	3	2	2

abnormal, of being marked. Because I had the prosthesis in the draw (in the hospital) I was able to put much of the worry out of my mind. I am sure I would have gone to pieces if I had not had it to wear home."

A third woman reported " You're terribly self-conscious; you walk with a bit of a stoop to try to hide it. I bought a prosthesis on the way home from the hospital; I couldn't go without it. It's vanity I suppose."

Widows Sample

As shown in Table VIII : 11 thirteen widows say the likelihood of their remarrying as very remote. They were predominantly middle class, financially secure and mothers of young children when their husbands died between 2 and 13 years ago. Another 2 had been widowed for 17 and 22 years respectively.

Of the 13 widows in this group, 9 had had no forewarning of their husband's death. One widow whose husband became ill and died within 6 weeks felt she had had no forewarning.

The younger half said they did not like their present life-style, they all said they found it difficult to imagine that anyone else could "measure up" to their husband in terms of the ideal they preserved and were favourably disposed to the idea of getting married again only " if the right man came along". (Only one reported she would entertain the idea of a de facto relationship.)

In the main these women were very aware of the social disadvantages of being lone women, all but one of them had experienced a strong sense of companionship in their marriage but because of their traditional outlook were not prepared to consciously go out in search of a husband. Most of their friends were married women (for the younger group) and widows (for the older group). In mixed company these women tended to have severe feelings of not belonging, of panic if left alone, of guilt, embarrassment and suspicion about their motives if other women's husbands spoke to them, of being "incomplete" and unable to "be themselves".

At the same time this group was aware of many reasons to fear another marriage. To experience the emotional trauma of the loss of a second husband seemed an unbearable prospect for most of them.

Table VIII:11 shows one third as reporting they definitely did not intend to remarry. This was a mixed group. 6 out of

the 11 were over 60 years of age and could be described as middle class, while of the younger 5, 4 were working class women. All but 2 of these widows had received forewarning of their husband's death. The older group, over 60 years of age, said they were prepared to "live with their memories", maintain their relationship with their families and live uncomplicated lives. These women had an accurate awareness of the fact that there were virtually no men available to marry anyway.

With the exception of one widow of 3 months standing, aged 50 years, the others were in their 30's and 40's. One was feeling very bitter towards men in general, having been involved in a de facto¹ relationship which had ended badly for her, one was currently living in a happy de facto relationship, one was involved with a man on a social basis only and one envisaged a continuing series of short-term de facto relationships with younger men.

Reasons for avoiding remarriage, as reported by widows in the first two categories in Table VIII:11, were : a reluctance to place themselves and their children in a position where they could become attached to another husband and father figure and perhaps lose him too, with the ensuing emotional anguish; the thought that the children came first and that they may be distressed if a replacement father were introduced;

a reluctance to give up their present independence as they perceived the marriage commitment required; a reluctance to run the risk of having to share material assets with the husband should a subsequent marriage fail.

Of the three who saw remarriage or a de facto relationship as equally acceptable, one was prepared to make substantial compromises in order to have a man to live with, because "a woman needs a man : it's only right. " The others aged 38 years and 59 years had both achieved a sense of independence and confidence enough to feel able to initiate relationships with men on a fairly equal basis and both admitted to a sexual and emotional need to establish a permanent relationship with a man. Two of these widows had received no forewarning of their husband's death.

Those who said they wanted to remarry comprised two working class widows in their 20's with young children who were actively seeking new husbands after 2.5 and 3 years of widowhood. Neither had had any forewarning of their husband's death.

The one widow who had remarried, whose husband was killed in a road accident said she did so mainly to escape the loneliness, the social and emotional discomfort of being

a widow with 2 young children to bring up alone, and as an escape from "continually looking backward as one inevitably does if one is not more or less in the mainstream of life in the present."

As was commonly the case with others who were contemplating entering normal society again, she had to make resolute efforts to be less withdrawn, to overcome feelings of incompleteness, social and emotional inadequacy, and to withstand many pressures she felt society at large and a number of individuals in particular, including her own mother, were exerting upon her to remain in the widow role, to "remain faithful" to her dead husband; to continue to mourn her loss. She reported that without the continued encouragement and support of one personal friend she would have retreated as one overcome by feelings of shame, guilt and lack of self-confidence.

Forewarning

Two - thirds of those who saw themselves remarrying as a very remote possibility had no forewarning of their husband's death while one fifth of those who definitely did not intend to remarry were also not forewarned.

Of the 6 who wished to remarry or live in a de facto relationship, and including the one widow who had remarried, 5 had no forewarning of their husband's death.

Work outside the Home

Without exception those women in both samples who went out to work reported this as contributing greatly to their rate of recovery. It helped to keep their minds off their loss. It also provided them with feelings of usefulness and belonging, and with an acceptable daily routine.

CHAPTER IX

DISCUSSION OF RESULTS

INTERVIEW LENGTH AND QUALITY

The differences in average length of the interviews between the mastectomy and the widows sample can be accounted for in several ways.

In general the widows tended to be more willing to describe in detail their loss and how it affected them. Perhaps it would be more accurate to say that once they began a compulsiveness overcame their expression making it impossible for them to stop until they had completed their account of the event. It is possible that the widows felt that to describe their loss experience, to talk about their husband and their relationship was an appropriate thing to do. The end of the marriage which had previously given them a status and a role now provided a legitimate topic of discussion. Despite feelings of demoralisation this was an area they knew well, and to have an interested listener gave the widow relief from the normal social pressure to avoid dwelling upon the death of their husband and its consequences. Nearly all widows perceived their loss as one of the most significant events in their lives with profound repercussions requiring immense effort to adjust to. Something which undoubtedly contributed

to this group being more willing to verbalise their experience was the fact that they had nearly all had a longer time between their loss and the interview to think through their feelings about it than the mastectomy group.

Women in the mastectomy sample generally tended to give an impression of brittleness, of being unwilling to fully review their experience. They frequently seemed reluctant to revive the emotion they reported themselves as having in relation to the threat of cancer. Many employed the type of defensive denial clichés referred to by Hackett and Cassem (1974) and used very determinedly optimistic and positive forms of expression. In general they gave an impression of trying to reduce the importance of the event in their minds: thus reducing associated anxiety.

Those for whom the experience had been most recent were able to describe the actual sequence of events in detail but seemed unable to verbalise many personal emotional responses to the experience. This group was excessively cheerful and attempted to discuss it briefly as a brush with disease and death : as something now over. On the other hand those who had had their mastectomy some years prior to the interview were, in general, more willing and able to express their past and current feelings about the experience. It was almost as if having survived this long they were not tempting fate by discussing the matter. Over the course of time either they had acquired a broader

perspective within which to accommodate the experience, or with the non-recurrence of cancer an unreality had interposed itself between them and the event.

In general the married women who had experienced mastectomy were more motivated to put the experience behind them than the widows in either group. These women had someone to recover for, and in order to appear normal they were eager to resume their usual roles and activities. It is significant to note that none of the married mastectomy group wished to continue in the patient role, and over all in the interview situation these were the women who were least willing to dwell upon the possibility of a recurrence of the disease. They seemed to see themselves as having the most to live for and thus the most to lose.

In general terms those who had no significant person to recover for presented a different picture in that they tended towards prolonged invalidism and were more emotional and more willing to spend longer in discussing their mastectomy experience. More will be said about this group in the discussion of Hypothesis 3.

Mastectomy is usually performed in an attempt to stop the spread of cancer. Only over the passing of time can the operation be said to have been successful. In the light of the fact that no-one can know in advance the outcome of such

surgery, successful adjustment to the threat of the disease and the resumption of a normal life-style must rely heavily upon a significant denial factor.

Thus for many of the mastectomy group to take part in the study meant giving attention to a topic they had many reasons on a number of levels to wish to avoid.

It is possible too, that to talk about someone else's death, as with the widows, is an easier task than to discuss or even contemplate one's own.

The manner in which contact was made with the two groups probably influenced the way in which the interviews progressed. The formal written approach used to invite the mastectomy women to participate aroused feelings of suspicion about confidentiality and the author's motives, and feelings of obligation to take part on the grounds that other women would benefit despite the fact that they did not really wish to talk about the event. In contrast, the informal method of contacting widows meant that they were usually asked to participate by people they knew and trusted. They felt they knew something of the author before the interview. The author often felt like a welcome visitor, but this was more frequently the case with widows who probably had more time to spend.

Interviewer experience also probably contributed to the varying lengths of interviews. As the author became more confident that the information being sought was forthcoming, and more practised at accepting information given, the interviews became more relaxed and longer.

DISCUSSION RELEVANT TO HYPOTHESIS 1

In general terms the results outlined in Chapter VIII support Hypothesis 1 (a) : that a similar initial grief reaction results from the loss of either a breast or a husband. The results demonstrate in both situations a movement from denial or avoidance to alarm reaction, to realisation and eventually to resolution or adjustment. At the same time, despite the similarity in the content and pattern of the reaction's movement, there is evidence of variation in terms of the severity and duration of the reaction.

The initial impact of the news that the breast symptoms indicates the probable presence of cancer and the need to surgically remove the breast was sufficiently threatening for most women to enter a state of shock or emotional numbness, as was the case when the widows were first told their husband was dying or had died. However as is shown in the results from Item 2 the mastectomy women were more quickly able to regain control over their emotions and actions than the widows. This suggests that the woman who had had to accommodate the news that she will lose a breast and possibly her life, faces a threat perceived to be of similar magnitude to that of the woman who is confronted with the news of the death of a husband.

Whilst the prospect of losing a breast was perceived as a threat often surrounded by fantasies of possible rejection by

others, it was also seen as a positive gesture towards saving the woman's life. For most the actual surgery became the immediate focus of attention against the backdrop of a more ominous and generalised threat. In this way those women were able to divide the threat up into manageable pieces in the manner White (1974) mentions. As recovery from the physical discomfort of the surgery was often fairly rapid the woman was encouraged by her progress. Her effort to resume normalcy was rewarded. This was not the case for the widows. The funeral serves as a parallel to the mastectomy operation in that it is the first event the widow must focus her attention on. Once she has completed this task though, she must begin to confront the reality of the loss of her husband and the whole set of subsequent accompanying losses. (Parkes;1971, Glick et al;1974) Without exception this was the case for the widows interviewed. However for the mastectomy group despite the fact that they had to somehow come to terms with the physical loss of a significant part of themselves, and accommodate the possible recurrence of cancer, they could hope for a continued normal life.

Responses to Item 7 probably give the clearest indication of the tendency on the part of the mastectomy group to minimise the emotional difficulties surrounding the operation and the prospect of a recurrence of cancer. At the time of the interview the vast majority of these women were physically well and

active, and it is suggested that such recovery served to alter their perception or memory of their original response to the event. The observation of Bozeman et al (1954) that events are reconstructed in the light of subsequent happenings or outcomes rather than recalled may be relevant to this minimising effect.

It is possible that in terms of the stages of grief outlined in Hypothesis 1 (a) many of the mastectomy group, while progressing through the sequence in relation to their breast loss have not moved beyond, or have had to revert back to, a denial stage when it comes to the management of their responses to the threat to their health and life. This is not to say that long periods of time were not spent in intense preoccupation with fantasies of long and painful illness culminating in death, and separation from loved persons, but rather to suggest that in the final analysis the only way for most women to reach some degree of resolution was to make good use of their capacity to deny. This was denial in the face of the fact that all that could be done had been done, a reasonable state of physical well-being had been regained, and to continue to entertain ideas associated with recurrence of the disease promoted the discomfort of the associated anxiety. It seems probable that anticipatory grief at the prospect of losing one's own life must take on an abbreviated form unless the person involved is continually given clear indications of her pending death.

Fantasies which inevitably accompany mastectomy do not usually become reality. Contrary to their worst fears their husbands did not reject them. In fact there is a good measure of evidence to suggest that the event reinforces the marriage relationship. This aspect will be more fully discussed in relation to Hypothesis 3.

All of the listed identifiable and interrelated features of the normal grief reaction as outlined in Hypothesis 1 b, are seen to be present in the results of both conditions. However the frequency, the degree of severity and the duration of the components as subjectively perceived by the women are different in the two samples.

In the early stages of the cycle a similar frequency of response is reported for the following features; initial shock reaction to forewarning, the sense of preoccupation with pending or actual loss, the recall of significant relevant dreams, the possibility of losing control over emotions or actions, feelings of anger, shame and guilt, the continuing sense of the presence of the lost object, the presence of physiological and psychological symptoms and a feeling of a loss of psychological intactness.

However, within a relatively short period of time significant differences in severity, duration and the frequency of reporting of many of these features are obvious. The widows cont-

inued to experience an intense pre-occupation with their loss, the physiological and psychological symptoms, continuing strong emotional pain and reduced self-esteem for significantly longer periods.

The widows within the mastectomy sample and those women who indicated a less satisfactory relationship with their husband, suffered acute, enduring feelings of psychological mutilation and significantly reduced self esteem. Certainly all of the women in the mastectomy sample keenly felt their physical mutilation and damaged self confidence but those in supportive primary relationships seemed more able to confine these feelings to the physical realm, and not allow them to generalise into other aspects of their self image.

For the widowed mastectomy group the whole experience of a further loss, this time of a physical aspect of their own body and possibly of their own health and life, comprised a threat of such proportions as to make them acutely aware of their vulnerability. This in turn re-activated the flood of emotional responses originally associated with the loss of their husband. It was sometimes difficult to distinguish between which loss this sub-group of women was talking about.

DISCUSSION RELEVANT TO HYPOTHESIS 3

Some women coped less well than others with the mastectomy experience and made only a partial or unsatisfactory adjustment to their breast loss. The same women rated the event as being unbearable or near the unbearable end of the continuum in Item 7 of the questionnaire schedule; they had not found a prosthesis which was satisfactory in appearance or comfort terms; they continued to experience the physiological and psychological symptoms of stress and they were the most prone to prolonged invalidism after their operation. With one exception these women were widows or reported themselves as having a less satisfactory relationship with husbands who "did not understand." This group lacked a significant other person to recover for. They lacked the motivation and habit strength to resume "normal" appearance and functioning. The mastectomy experience revived strong grief reactions associated with their husband's death, and constituted a second assault on them.

With the exception of one widow those women who coped best with mastectomy reported a high level of satisfaction with their husband's understanding and support throughout the experience. Two thirds of the married group described their husbands as "absolutely marvellous" or something similar, in the way they performed throughout the event, and stated that their high degree of acceptance of and adjustment to their breast loss was due to their husband's support and encouragement.

Both the women facing mastectomy and their husbands, as reported by the women themselves, were extremely distressed by the sequence of events surrounding the operation. They could be described as being highly emotionally aroused. Very often however, much of this arousal was turned in a very positive direction. In responding to their husband's concern these women were able to maintain a sense of personal worth and a high degree of emotional intactness and control. They had something to hang on to and this focus seemed to act as a stress levelling instrument. Within such a relationship this group was more able to verbalise their fears and keep up to date with how they felt about what was happening to them. This provided them with a sense of space within which to move and as a result they seemed able to receive the rewards the emotional contact with their husbands provided. In the face of the possibility of their losing each other these couples used the situation to express feelings and to be more demonstrative of their affections than they had possibly ever been before. Thus the event was a strongly reinforcing one with the husband rising to the occasion in a protective and supporting role. Often it became an occasion for reviewing their lives together and significant shared experiences were revived. These emotionally reinforcing gestures did much to reduce the woman's tendency to feel embarrassed, self conscious, ashamed and disappointed at the physical mutilation sustained.

These women were strongly motivated to resume normalcy in order

to reduce not only their own anxiety but also that of their husband and family. Their determined efforts at physical tasks like spring cleaning, gardening, helping on the farm, resuming old sports like bowls and tennis, and in some cases, taking up new activities and hobbies can be interpreted in several ways. Certainly it can be seen as anxiety reducing activity or the expression of restlessness normally associated with a response to threat, or it can be interpreted as an attempt to requalify as a fully functioning, normal, robust person. In working hard at regaining the greater proportion of their former physical strength and fitness, and by keeping fully occupied they demonstrated to themselves and others their control over themselves and above all their usefulness as active, participating people. In such circumstances the recurrence of cancer seemed remote and the compulsion towards preoccupation receded. Responses to Item 16 show a significant difference in the subjective assessment of both the amount of change to lifestyle and attitude to life, and the degree of accompanying personal gain occurred between the mastectomy sample and the widows sample. The author interprets this as an indication of need to change, and of the amount of effort required to bring about such a change : the greater the effort required the greater the satisfaction from succeeding. Clearly the need for the mastectomy sample was not similar to that of the widows. In day to day living terms mastectomy does not affect every aspect of the woman's life as being widowed does.

The widows results of this study confirm the findings of Averil (1968) Parkes (1970, 1971) Marris (1958) and Glick et al (1974) and are recorded in Appendix 4.

A train of interrelated features and events are set in motion with the widow where, in her intense state of preoccupation with her loss she is often inaccessible and unrewarding to those who offer support. Invitations, gestures of encouragement and inclusion are often misinterpreted, ignored or met with hostility; the widow feels alone and isolated, that others cannot understand and that she is no longer socially acceptable. This sequence of responses is circular. In the same way as Parkes (1970, 1971), Glick et al (1974) and Gut (1974) point out, this study confirms the fact that the widow finds herself ill equipped to lead a satisfactory life as a single person. What was regarded as appropriate and healthy in a wife, and a normal woman (Broverman et al, 1975) is no longer a useful set of behaviours and attitudes to hold if the woman is to make a satisfactory adjustment to widowhood.

Reponses to Item 16 lend support to the findings of other studies previously cited that, to survive, the widow is forced to bring about some very fundamental changes in her orientation and practical approaches to life.

None of this needs to be the case for the woman who has undergone mastectomy. However, if she does resolve to expand her horizons and take advantage of the unknown time she may have left by

embarking upon new interests she is almost invariably encouraged.

For the woman who regains and maintains a reasonable level of physical fitness the reality of her situation is different from what she originally feared. Her husband has not rejected her. She is usually able to find a satisfactory prosthesis and with some modification to the way she dresses she is not detected as someone physically different. She is able to pursue her normal activities and interests. Her wifely and parenting roles have not changed. She has been shown in convincing terms by her friends and realations that she is valued. The threat of recurring cancer is constantly with her but the findings of this study seem to show that so long as good health is maintained this threat recedes markedly.

DISCUSSION RELEVANT TO HYPOTHESIS 2

Hypothesis 2 suggests that forewarning of the event will result in a less severe initial response to the actual loss and a more rapid recovery, on the basis that it is possible for the individual to emotionally prepare for, or inoculate against an aversive or threatening event : Janis (1958 and 1971).

The results from the mastectomy experience sample offer some support for the notion that forewarning has some influence on the individual's response to the event. All of the mastectomy group, with one possible exception, were given some measure of forewarning that they would lose a breast. They said they either clung to the hope that when the time came it would not prove necessary for their breast to be removed, or they decided on an insurance policy type basis, to try in advance to make a reality of losing their breast on the grounds that what happened then could only be what they had prepared themselves for, or better. The fact that within the mastectomy sample half of each category (possible, and almost definite breast loss) were able to realise loss immediately when coming out of the anaesthetic suggests that the deciding factor in preparation was neither the degree of likelihood given in the warning, nor what the woman stated to be her strategy for anticipating the loss, but what, on a subconscious level, the woman did with the warning.

In fact it is probable that all women simultaneously used both of the coping strategies previously mentioned. Other factors contributing to the way they coped could have been; the manner in which the doctor presented the initial information, the degree to which the woman had developed a "mature body image", the degree of security the woman felt about her relationship with her husband, and the presence or absence of a significant other person in her life.

Certainly it can be said that self inoculation worked for half of the sample; five women reported no surprise or shock at the medical diagnosis on the grounds that they had already accurately identified their own condition and were aware of the probable surgical procedure; and a further ten women, after a shock response to the initial suggestion of a cancer diagnosis and breast removal, somehow defended themselves against a further shock or emotional numbing response when confronted with the reality of their breast loss.

Taking into account the fact that the number of widows who received forewarning of their husband's death was smaller, the type of warning and the actual event, and the course the illness would follow; the results of this study seem to indicate that forewarning of the pending death of a husband has less effect upon the widow's initial mode of response to the actual death. Only one of the forewarned widows met the news of her husband's death without an initial shock and

numbing response. This same widow did not differ from the rest in terms of the severity and duration of her ultimate grief reaction.

One possible explanation for this difference between the forewarned in each sample is that while the woman who has breast cancer has no control over the disease she may feel she is exercising some level of control over whether or not the breast is to be removed. Although most women felt they had been given no choice in the matter, and few felt they were capable of making a rational decision at the time or even wanted this responsibility, by not refusing to have the operation performed it can be suggested that they had taken part in the procedure. They had contributed to an action which they believed could help to eliminate the greater threat to their life. The widows had no similar sense of participation or control over the course of events surrounding their husband's death.

The rate at which widows recognised their loss for the first time tended to be slower than that of the women who underwent mastectomy. However, after one week all but three in the mastectomy sample and five widows reported they had consciously recognised and responded to their loss.

Subsequent realisations by the widows tended to occur over a longer time period as various significant aspects of their

lives were encountered alone. For the woman who had lost a breast however there were fewer and less varied situations in which she had to face the fact of her loss. She got more practice at taking in the fact in much the same circumstances daily. Otherwise in this culture her absence of a breast is normally as compulsory a secret as its previous presence was. Others will continue to respond to her normally.

INFORMATION THAT EMERGED WHICH WAS NOT DIRECTLY RELEVANT
TO THE HYPOTHESES.

Two women who had modified operations where about one third of the fullness of the breast was preserved. This meant that these women were left with a good deal of the normal feeling of softness associated with breasts, which they found comforting and surprisingly reassuring. It also meant that they felt they could wear clothing with a lower neckline in a way that those who had had the more usual surgery felt they could not.

The strangeness of having a boney fleshless appearance and sensation was reported to be very distressing at first. Very few women went out into the company of others before they were fitted with a prosthesis. Those who did felt that everyone was staring at their deformity. Even after they had their prothesis many women continued to fear detection. This is in line with the observations of Bard and Sutherland (1955) and can be interpreted as a fear not only of the stigmatisation that often accompanies physical deformity, but also of being regarded as an outcast because of the disease itself.

Those women who lost both breasts reported responses to the second encounter with cancer, and the second mastectomy operation on a number of levels. They said that it was only when they had lost their second breast that they realised how significant a part of them they had regarded it as being. The

total flatness of the chest area seemed more dramatically unfamiliar than the loss of one breast had been. They did feel totally stripped of their main outward manifestations of femininity. This supports the observation of Leis (1971) that the remaining breast is treasured as a sign of femininity and motherhood. However, none of these women nor any in the sample made any statements to the effect that because their female characteristics had been diminished they were therefore masculine or "halfman - halfwoman" as Bard and Sutherland (1955) report.

The fact that nearly all of those with one remaining breast reported that they perform frequent and systematic checks (some daily) for further symptoms of breast cancer lends support to the theory (Leis 1971) that this one breast is also regarded with ambivalence; as a threat, and a constant reminder of the possible presence of the disease. To check and find no symptoms serves to temporarily relieve this anxiety.

The ten women who said they would have appreciated someone who had had the same mastectomy experience, visit them, or be available to talk with before, during or after hospitalisation, offered this information unsolicited. It is therefore reasonable to suggest that a higher proportion of the sample may have felt they would have benefited from such a service or group membership. Those who found themselves in hospital with other mastectomy patients invariably reported a positive aspect

to this; either as having had their support, or as having themselves, been able to help another woman through the stress of the operation. All but two of the out of town women who stayed at a local residence especially established for people no longer requiring hospital care, but needing to be available for near daily radiation treatment and check-ups at the hospital, reported this as being a highly supportive experience. It provided them with an opportunity to work through their initial pre-occupation with their loss and their fears in an empathetic and permissive atmosphere. The other side of this was that in turn they felt able to give support to others, at a time when they needed to feel useful.

While in hospital only one woman had had the opportunity to join a therapy group run by one of the social workers employed by the hospital. This group was made up of women who had had hysterectomies and this one mastectomy patient. She reported having been greatly helped by the opportunity to express her fears and emotions at the time within the security of the organisation of a non-directive, non-judgemental supportive and empathetic group with a skilled facilitator.

These personal accounts give support to the opinions of Klein (1971) and Trachenberg (1971) concerning the beneficial effect of group counselling and group membership.

The expectation that the surgeon will ideally provide the woman with adequate personal attention, understanding and enough time for her to properly explore and express her fears and emotions as suggested should be the case, by Bard and Sutherland (1955), is unrealistic. The inevitable outcome of the discrepancy between the ideal and what in fact happens is that the women concerned frequently feel they have been too rapidly steered through a series of events about which they have very complex feelings, which they have been unable to work through in advance or en route. In turn this probably serves to magnify feelings of vulnerability, lack of control over what happens to them, dependency and intense threat, which they will have anyway. While some women have husbands or close friends with whom they can talk, a significant proportion have no-one available at the time of diagnosis, surgery or when they return home. While women who are fortunate enough to be in supportive close relationships would also probably benefit from counselling, it is the less well supported women who are most prone to wanting more from their relationship with the surgeon than is realistically possible to expect.

The highly vulnerable emotional condition of the woman confronting the threat of mastectomy and cancer, and the interpretation she can put on the actions of surgeons is demonstrated in the following finding.

Reponses to Item 8 relating to self-esteem, which were incidental to the main thrust of the item, but were consistent over the separate reports of four individually interviewed women can confidently be regarded as more than a coincidence.

They perceived a particular surgeon as very caring, genuinely concerned about their well being, and interested in them on a person to person level. This feeling of being personally cared for continued right up till the actual surgery.

Afterwards, however, they felt this surgeon to be cold, distant and uncaring in his attitude towards them, leaving them with strong feelings of being abandoned or discarded, at a time when they were in particular need of support.

The author gained an impression that in overall terms these women could equally well have been describing a seduction at best, or at worst, a rape. It was common to all four that they felt they had been led trustingly into the operation but were left to feel abandoned, used and violated afterwards.

It is fairly commonly understood that many women entertain romantic fantasies about their doctors, and in these circumstances they are undoubtedly more predisposed to idealising or ascribing magical powers to, or putting private interpretations upon the gestures of one seen to be so powerful

and filled with status as a surgeon.

The notion of the strongly emotionally aroused state typical of persons who have been recently confronted with extremely threatening information applies to women facing mastectomy and leaves them vulnerable to a wide range of intense emotions as they search for some person or thing to hang on to for support.

It seems reasonable to assume that in order to survive in their occupation surgeons cannot really afford to become too involved in the feelings of their patients. By insulating themselves emotionally they cannot be said to be fit persons to offer the kind of support many people need when trying to cope with a life threatening event. This raises the question; to what extent should the hospital exercise responsibility for helping to safeguard the emotional well-being of its patients? If patients are to be seen as having an emotional aspect to their make-up, and if the hospital is concerned with the whole person, then proper provision should be made to assist those who lack adequate support outside of the hospital setting.

CONCLUSION

This research shows that the mastectomy experience is sufficiently threatening to elicit most of the basic features of a full acute grief reaction as outlined by Linemann (1944). It also demonstrates that it is an event which requires much concentration of the woman's resources to gain control over her emotions and actions.

Apart from the fact that the woman must adjust to the loss of a significant part of her body and identity as a woman, she has to learn to cope with the threat of a disease which conjures vivid visions of a long and painful illness and death, and which may recur at any time. Achieving a way of coming to terms with this factor of the unknown sets the experience apart from widowhood and even the strongest defenses break down from time to time uncovering a threat few people would willingly encounter.

PRACTICAL RECOMMENDATIONS

1. That adequately qualified therapists and/or social workers in association with psychologists, physiotherapists and members of the medical profession be employed by a publicly funded agency to organise and facilitate individual and group counselling for women and their husbands before, during and after her hospitalisation for mastectomy, should they wish to use such a service.

Some functions of such counselling would be the provision of the opportunity for women and their husbands to fully explore and express their responses to the situation they found themselves in, the provision of a safe, supportive and encouraging environment to assist individual women to adjust to their loss and the threat to their lives, and the sympathetic giving out of information about prostheses, government grants for prostheses, suitable exercises for strengthening the arm and shoulder, techniques for performing basic tasks in the early stages of recovery.
2. That social workers in the hospital setting take particular note of widows and others who do not appear to have adequate emotional support when

facing the prospect of mastectomy. This group need the most support, especially after they leave the hospital.

3. That members of the medical profession ensure a consistent manner when dealing with women who undergo mastectomy.

Appendix 1

PALMERSTON NORTH HOSPITAL

Private Bag,
Palmerston North,
New Zealand.

Dear Madam,

I have accepted a request from a research student, Mrs. Diana Parsons, of the Psychology Department of Massey University, to ask a large number of women if they would be willing to take part in an interview survey of how women cope with mastectomy. It is hoped that information gathered from such a survey will help other women to more successfully cope with their operation.

If you are willing to be interviewed please write your name, address and telephone number on the card provided and return it in the enclosed stamped envelope to Mrs. Diana Parsons, 17 Sutherland Crescent, Palmerston North, as soon as possible. She will contact you and arrange a convenient time and place for the interview. If you wish to know more about the survey before you make up your mind, you may telephone her at her home, phone 73 584.

If you do not wish to take part in the survey you do not need to advise either Mrs. Parsons or me. Mrs. Parsons has

Appendix 1

not been given your name, or any information about you.

Apart from myself, no-one is aware that you have been invited to participate.

I would stress that taking part in this survey is quite voluntary, and if you do participate anything you say will be kept strictly confidential to Mrs. Parsons only. If a report is published as a result of this survey no individual person will be identifiable in any way.

Your participation in this survey is invited.

Yours faithfully,

Deputy Medical Superintendant.

Appendix 2

PALMERSTON NORTH HOSPITAL

Private Bag,
Palmerston North,
New Zealand.

Dear Madam,

A short time ago you received a letter from me inviting you to be interviewed by Mrs. Diana Parsons of the Psychology Department of Massey University about how you coped with your mastectomy.

The original letter stressed that you do not have to take part in this survey. We respect your wishes in this matter. However, in case you may have forgotten and still wish to take part in the survey, I enclose another card and a stamped envelope addressed to Mrs. Parsons.

Again I would stress that taking part in this survey is quite voluntary, and if you do participate anything you say will be kept strictly confidential to Mrs. Parsons only. If a report is published as a result of this survey no individual person will be identified in any way.

Yours faithfully,

Deputy Medical Superintendent.

Appendix 3RAW DATA: COMPARISON BETWEEN MASTECTOMY AND OTHER EVENT, WIDOWHOOD AND OTHER EVENTUSING 9 POINT SCALE FROM UNBEARABLE(1) TO BEARABLE(9)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Number:Subject
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	3	4	5	5	5	8	9	Rating:Widowhood
-	-	-	-	-	-	-	-	-	-	-	-	-	-	3	3	4	1	1	5	5	5	5	5	6	1	5	5	1	5	Rating:Other event
5	5	5	5	5	5	5	5	5	5	5	5	5	5	2	3	4	4	3	3	3	4	4	3	4	3	4	4	4	4	Category of other Event
1	1	1	1	3	4	5	5	5	5	6	6	6	6	7	7	7	7	8	8	8	8	9	9	9	9	9	9	9	9	Rating : Mastectomy
1	1	1	1	6	6	1	1	4	9	2	2	3	4	1	1	3	5	1	2	2	2	1	1	1	1	1	2	3	5	Rating:Other event
1	1	1	4	4	3	1	1	3	3	3	4	4	1	1	4	3	4	1	1	2	3	1	2	4	4	4	3	4	1	Category of other Event

Category of Other Event

1. Death of Spouse
2. Death of child; son, daughter
3. Death of parent
4. Other event
5. No other event compares

Appendix 4

INCIDENCE OF SOME COMMON FEATURES IN STUDIES OF WIDOWS

	This Study	Harvard Study (1973)	Glick et al Study (1974)	Marris Study (1958)	London Study (Parkes 1971)
Shock, numbness 97%					
non-comprehension					
shock beyond a few hours 64%			64%		
Fear of losing control 37%			38%(feared nervous breakdowns)		
Thoughts of Suicide 33%			28%(would welcome own death after one year)		
Anger-blames someone else for husband's death 30%				15%	45%
Guilt-blames self for husband's death 17%				11%	18%
Sense of presence of dead husband 57%				50%	68%(1st weeks) 55%(1yr)
"Why did this have to happen to me?" 70%			58%		
Increased Weeping 87%			92%		73%
Lack of Appetite 90%		50%			86%(after 1 month)
Weight loss 57%			26%		68%(after 1month)
Difficulty getting to sleep 83% (27% 1yr)		28% (1yr)	40% (3wks)	79%	77%

Appendix 4.

Sleep Disturbances	90% (43% 1yr)	40% (1yr)	40% (3 wks)	
Inability to concentrate	77%		60%	
Restlessness	76%	49%		82%(1 month)
Irritability	27%		51%(1yr)	
Inability to make decisions	70%	53%		
Preoccupation with loss	27%(1yr)			55%(1yr)
Increased smoking	20%	28%		
Increased Alcohol Consumption	23%	28%		
Used tranquillizers, sleeping pills	43%	26%		55%
Isolation, Remote feelings	73%	34%		82%

BIBLIOGRAPHY

ADAMS, B. H. and BUTLER, J. E.

Occupational status and husband - wife social participation.
Social forces 45 (4) : 501 - 507, 1967.

ADAMS, J. E. and LINDEMANN, E.

Coping with long-term disability. In G. V. Coelho, D. A. Hamburg and J. E. Adams, eds. Coping and adaptation. New York Basic Books, inc. Publishers, 1974.

AITKEN - SWAN, J. and EASSON E. C.

Reactions of cancer patients on being told their diagnosis.
British medical journal 1 : 779, 1959.

AKEHURST, A. C.

Post-mastectomy morale. Lancet 2 : 181, 182, 1972.

ALDRICH, C. K.

The dying patient's grief. J. Amer. med. assoc. 184 : 329, 1963.

ANSTICE, E.

Coping after mastectomy. Nursing times 66 : 882 - 883, 1970.

/ ANSTICE, E.

The emotional operation. Nursing times 66 : 837 - 838, 1970.

ASCH, S. E.

Social psychology. Englewood Cliffs, N.J., Prentice - Hall, 1952.

AVERILL, J. R.

Grief : its nature and significance. Psychological bulletin
70 (6) : 721 - 743, 1968.

BABCHUK, N. and BATES, A.P.

The primary relations of middle-class couples : A study in male dominance. American sociological review 28, 377 - 384, 1963.

BARD, M.

The sequence of emotional reactions in radical mastectomy patients. Public health report 67 : 1144 - 1148, 1952.

BARD, M. and SUTHERLAND, A.

Psychological impact of cancer and its treatment. Cancer 8 (4): 656 - 672, 1955.

BEEBY, J. and BROEG, P. E., 2nd.

Treatment of patients with radical mastectomies. Physical therapy 50 : 40 - 43, 1970.

BERNARD, J.

The future of marriage. N.Y. World (Bantam Books), 1973

BOUCHARD, R. and OWENS, N. F.

Nursing care of the cancer patient, 3rd ed, St Louis, The C.V. Mosby Company, 1976.

BOWLBY, J.

Attachment, Vol 1, Attachment and loss London : Hogarth : New York : Basic Books, 1969.

BOWLBY, J.

Grief and mourning in infancy and early childhood. Psychoanalytic study of the child 15 : 9 - 52, 1960.

BOWLBY, J.

Pathological mourning and childhood mourning. Journal of the American Psychoanalytic Association 11 : 500 - 541, 1963.

BOWLBY, J.

Process of mourning. International journal of psycho-analysis 42 : 317 - 340, 1961 a.

BOZEMAN, M. F., ORBACH, C. E. and SUTHERLAND, A. M.

Psychological impact of cancer and its treatment : III The adaptation of mothers to the threatened loss of their children through leukemia : Part 1 Cancer 8 (1) : 1 - 19, 1955

BREAST PROTHESIS SUBSIDY

New Zealand medical journal, Vol 84 : 168, 1976.

BREWSTER, H.

Separation reaction in psychosomatic disease and neurosis.

Psychosomatic medicine 14 : 154, 1952.

BROVERMAN, I. K. et al

Sex-role stereotypes and clinical judgements of mental health, P 163 - 176. In Unger, R. K. and Denmark F. L. eds, Woman : dependent or independent variable ? N.Y. Psychological Dimensions, Inc., 1975.

CAINE, L.

Widow. N.Y., William Morrow, 1974.

CANCER DATA.

New Zealand health statistics report, National health statistics centre, Dept. of Health, 1976.

CAPLAN, G.

An approach to community mental health. London, Tavistock publications, 1961.

CARPENTER, C. R.

Societies of monkeys and apes. Biological symposia 8 : 177 - 204, 1942.

CASEY, R. L., MASUDA, M. and HOLMES, T. H.

Quantitative study of recall of life events. Journal of psychosomatic research 11 : 239 - 247. Pergamon Press, 1967.

CLARK, R. L., MORETON, R. D. and HEALEY, J. E.

Rehabilitation of the cancer patient. Cancer 20 : 839 - 845, 1967.

COGSWELL, B.

Rehabilitation of the paraplegic: Processes of socialisation. Soc. Inq. 37 : 11, 1967.

CROOG, S. H. SHAPIRO, D. S. and LEVINE, S.

Denial among male heart patients. Psychosomatic medicine 33 : 385, 1971.

DIETZ, H.

Commentary on "psychologic adjustment to mastectomy." Medical aspects of human sexuality 7 : 65, 1973.

DIETZ, J. H.

Rehabilitation of the cancer patient. Medical clinics of North America 53 : 607 - 624, 1969.

DOMINIAN, J.

Depression, London, Fontana, 1976.

EGBERT, L. D., BATTIT, G. E., WELCH, C. E. and BARTLETT, M. K.

Reduction of post-operative pain by encouragement and instruction of patients. New England journal of medicine, 270 : 825 - 827, 1964.

EIBL - EIBESFELDT, I.

Grundriss der vergleichenden verhaltensforschung. Munchen, Piper, 1967.

ENGEL, G. L.

Psychological development in health and disease. Saunders, Philadelphia, 1962.

ERVIN, C. S.

Psychologic adjustment to mastectomy. Medical aspects of human sexuality 7 : 42 - 65, 1973.

FALEK, A. and BRITTON, S.

Phases in coping : the hypothesis and its implications. Social biology 21 (1) Spring, 1974.

FENICHEL, O.

The psychoanalytical theory of neurosis. New York : W.W. Norton and Company, 1945.

FESTINGER, L. and KATZ, D. eds.

Research methods in the behavioural sciences. New York, Dryden Press, 1953.

FISHER, S. H.

Psychiatric considerations of hand disability. Arch. phys. med. rehab. 41 : 62, 1960.

FREUD, ANNA.

The ego and the mechanisms of defense. New York, International Universities Press, 1946.

FREUD, S.

Mourning and melancholia. (Orig. publ. 1917) In J. Strachey. ed. The standard edition of the complete psychological works of Sigmund Freud. Vol 14. London : Hogarth, 1957.

FRIED, M.

Grieving for a lost home. In L. J. Duhl. ed. The urban condition. N. Y., Basic Books, 1963.

GILBERTSON, V. A. and WANGENSTEEN, O. H.

The physician and the total care of the cancer patient.
N.Y., American cancer society publication, 1962.

GLICK, I. O., WEISS, R. S. and PARKES, C. M.

The first year of bereavement. New York; Wiley, 1974.

GOLDSMITH, H. S. and ALDAY E. S.

Role of the surgeon in the rehabilitation of the breast cancer patient. Cancer 28 : 1672 - 1675, 1971.

GORER, G.

Death, grief and mourning. London, Cressent Press, 1965.

GUILFORD, J. P.

Psychometric methods, 2nd ed. New York, McGraw-Hill, 1954.

GUT, E.

Some aspects of adult mourning. Omega, 5 (4), 1974

HAAN, N. and DAY D. A.

A longitudinal study of change and sameness in personality development, adolescence to later adulthood. Aging and human development, 5 (1) : 11 - 39, 1974.

HACKER, H. M.

Women as a minority group, P 85 - 102. In Unger, R. K. and Denmark, F. L. eds. Woman : dependent or independent variable ? N.Y. Psychological Dimensions, Inc., 1975.

HACKETT, T. P. and CASSEM, N. H.

Development of a quantitative rating scale to assess denial, Journal of psychosomatic research 18 : 93 - 100, Pergamon Press, 1974.

HAIG, G.

Defensive behaviour in client-centred therapy. Journal of consult. psychol. 13 : 181 - 189, 1949.

HAMBURG, D. A. and HAMBURG, B.

Adaptive problems and mechanisms in severely burned patients. Psychiatry 16 : 1, 1953.

HARRELL, H. C.

To lose a breast. American journal of nursing 72 : 676 - 677, 1972.

HEALEY, J. E. Jr.

Role of rehabilitation medicine in the case of the patient with breast cancer. Cancer 28 : 1666 - 1671, 1971.

HESS, B.

Friendship. In M. W. Riley, M. Johnson and A. Foner, eds. Aging and society, Vol 3, N.Y. Russell Sage Foundation, 1972.

Holmes, T. H. and Masuda, M.

Life change and illness susceptibility. In B.S. Dohrenwend and B.P. Dohrenwend, Stressful life events : Their nature and effects. N.Y. John Wiley, 1974.

HOLMES, T. H. and Rahe, R. H.

The social readjustment rating scale. Journal of psychosomatic research 11 : 213 - 218, 1967

Horner, M. S.

Femininity and successful achievement : A basic inconsistency. In J. Bardwick, E. Douvan, M. Horner and D. Gutman, Feminine personality and conflict. P45 - 74. Belmont, California, Brooks / Cole, 1970.

IZARD, C. E.

Patterns of emotions. N. Y. Academic press, 1972.

JAMES, W.

Psychology. N. Y. Holt, 1892.

JANIS, I. L.

Psychological stress. N.Y. Wiley, 1958.

JANIS, I. L.

Stress and frustration. N.Y. Harcourt Brace Jovanovich, 1971.

JANIS, I. L. and LEVENTHAL, H.

Psychological aspects of physical illness and hospital care.

In Wolman, B. ed. Handbook of clinical psychology. N.Y. McGraw - Hill, 1965.

JONES, D.

Sex differences in the friendship patterns of young adults.
Unpublished paper, 1974.

KAHN, R. L. and CANNELL, C. F.

The dynamics of interviewing. N.Y. Wiley, 1957.

KANGAS, J., and BRADWAY, K.

Intelligence at middle-age: A 38 year follow-up. Develop-
mental psychology 5, 333 - 337, 1971.

KASTENBAUM, R.

Death and bereavement in later life. In Kutscher, A. H. ed.
Death and bereavement in later life. Springfield, Illinois,
C.C. Thomas, 1969.

KENNEL, J. H., SLYTER, H. and KLAUS, M. H.

The mourning response of parents to the death of a newborn
infant. New England journal of medicine 283 : 344, 1970.

KLEIN, R.

A crisis to grow on. Cancer 28 : 1660 - 1665, 1971

KORCHIN, S. and RUFF, G.

Personality characteristics of the mercury astronauts.

In Grosser, G. H., Wechsler, H. and Greenblatt, M. eds.

The threat of impending disaster : Contributions to the psychology of stress. Cambridge, Mass. M.I.T. Press, 1964.

KRAUS, A. S. and LILLIENFELD, A. M.

Some epidemiologic aspects of the high mortality rate in the young widowed group. Journal of chronic disability 10 : 207 - 217, 1959.

KUBLER - ROSS, E.

On death and dying, N.Y. Macmillan, 1969.

LASSER, THERESE and CLARKE, WILLIAM KENDALL.

Reach to recovery. Simon and Schuster, 1972.

LAZARUS, R. S.

Psychological stress and the coping process. N.Y. McGraw - Hill Book Company, 1966.

LEIS H. P. Jr.

Selective, elective, prophylactic, contralateral mastectomy.
Cancer 28 : 956 - 961, 1971

LEWIN, B.

The psychoanalysis of elation. N.Y. Norton, 1950.

LEWIS, C. S.

A grief observed. London, Faber, 1961.

LIFTON, R. J.

Death in life. U.S.A. Random House, 1967.

LIFTON, R. J.

Home by ship : Reaction patterns of American prisoners of war repatriated from North Korea. Am. j. psychiat. 110 : 732, 1954.

LILIENFELD, A. M.

The epidemiology of breast cancer. Cancer Research 23 : 1503 - 1513, 1963.

LINDEMANN, E.

Psychiatric factors in the treatment of ulcerative colitis. Archives of neurology and psychiatry 53 : 322, 1945.

LINDEMANN, E.

Symptomatology and management of acute grief. American journal of psychiatry 101 : 141, 1944.

LOPATA, H. Z.

Widowhood in an American city. Cambridge, Mass., Schenkman Publishing Co, 1973.

LOWENBERG, J. S.

The coping behaviours of fatally ill adolescents and their parents, Nursing forum 9 (3), 1970.

LOWENTHAL, M. F. and CHIRIBOGA, D.

Transition to the empty nest. Archives of general psychiatry 26 : 8 - 14, 1972.

LOWENTHAL, M. and C. HAVEN.

Interaction and adaptation : Intimacy as a critical variable. American sociological review, 33(1) : 20 - 30, 1968.

McDERMOTT, N. T. and COBB, S.

A psychiatric survey of 50 cases of bronchial asthma. Psychomatic medicine 1 : 203, 1939

McGRATH, J.

Social and psychological factors in stress. N.Y. Holt, Rinehart and Winston, 1970.

MANDELBAUM, D. G.

Social uses of funeral rites. In Feifel, H. ed. The meaning of death. N.Y. McGraw - Hill, 1959. (Reprinted In Fulton, R. ed. Death and identity. N.Y. Wiley, 1965.)

MADDISON, D. and VIOLA, A.

The health of widows in the year following bereavement. Journal of psychosomatic research 12 : 297, 1968.

MARKEL, W. M.

The American cancer society's programme for the rehabilitation of the breast cancer patient. Cancer 28 : 1676 - 1678, 1971.

MARRIS, P.

Widows and their families. London, Routledge and Kegan Paul, 1958.

MEAD, MARGARET.

Male and female; a study of the sexes in a changing world. N.Y., Morrow, 1949.

MECHANIC, D.

Social structure and personal adaptation; some neglected dimensions. In Coelho, G.V., Hamburg, D.A. and Adams, J.E. eds. Coping and adaptation, N.Y. Basic Books, Inc, 1974.

MECHANIC, D. and NEWTON, M.

Some problems in the analysis of morbidity data. Journal of chronic disease 18 : 569 - 580, 1965.

MENNINGER, K. A.

Regulatory devices of the ego under major stress. International journal of psychoanalysis 35: 412 - 420, 1954.

MILLARD, D. R., DEVINE, J. Jr., and WARREN, W.D.

Breast reconstruction : a plea for saving the uninvolved nipple. American journal of surgery 122 : 763 - 764, 1971.

MILLER, D. R. and SWANSON, G. E.

Inner conflict and defense. N.Y. Holt, Rinehart and Winston, 1960.

MOOS, R. H. and TSU, V. D.

Human competence and coping : an overview. In Moos, R. H. ed. Human adaptation. London, D.C. Heath and Company, 1976.

MORRIS, DESMOND.

The naked ape. N.Y., Penguin Books, 1967.

NEUGARTEN, B. et al (eds)

Personality in middle and late life. N.Y., Atherton, 1964.

NEW ZEALAND CENSUS OF POPULATION AND DWELLINGS,

Department of Statistics publication, Wellington, 1971.

NEW ZEALAND OFFICIAL YEAR BOOK,

Wellington, Department of Statistics, 1977.

OPPENHEIM, A.N.

Questionnaire design and attitude measurement. London, Heineman, 1966.

PARKES, C. M.

Bereavement and mental illness. Pt. 1. A clinical study of the grief of bereaved psychiatric patients. Pt. 2. A classification of bereavement reactions. British journal of medical psychology 38 : 1, 1965.

PARKES, C. M.

Bereavement ; studies of grief in adult life. Tavistock Publications, London, 1972.

PARKES, C. M.

Components of the reaction to loss of a limb, spouse or home. Journal of psychosomatic research 16 : 343 - 349, 1972.

PARKES, C. M.

The effects of bereavement on physical and mental health : a study of the case records of widows. British medical journal, (2) : 274, 1964 b.

PARKES, C. M.

The first year of bereavement : a longitudinal study of the reaction of London widows to the death of their husbands. Psychiatry 33 : 444, 1970 b.

PARKES, C. M.

Recent bereavement as a cause of mental illness. British journal of psychiatry 110 : 198, 1964 a.

PARKES, C. M.

The psychosomatic effects of bereavement. In Hill, O.W. ed. Modern trends in psychosomatic medicine. 2 London, Butterworth, 1970 a.

PLAYBOY

Chicago, Playboy Enterprises, Inc., 1:1, 1953.

REES, W. D. and LUTKINS, S. G.

Mortality of bereavement. British medical journal (4) : 13, 1967.

RENNEKER, R. and CUTLER, M.

Psychological problems of adjustment to cancer of the breast. Journal of the American medical association 148 : 833-838, 1952.

ROBERTS, M. M. FURNIVAL S. G. and FORREST, A. P. M.

The morbidity of mastectomy. British journal of surgery
59 : 301 - 302, 1972.

ROBINSON, N.

Sweet breathes the breast, Blackwood, Lynton Publications
Pty. Ltd., 1974.

ROCHLIN, G.

Man's aggression; the defence of the self. London,
Constable, 1973.

ROGERS, C.

On becoming a person. Boston : Houghton Mifflin, 1961.

ROSS, D.

The story of the top one percent of the women at
Michigan State University. Unpublished study cited In
Bernard, J., The future of marriage. N.Y., World
(Bantam Books), 1973.

ROTTER, J.

Generalised expectancies for internal versus external
control of reinforcement. Psychological monographs 80
(1, Whole no. 609), 1966.

SCHILDER, P.

Psychotherapy. N.Y., W.W. Norton, 1951.

SCHILDER, P. F.

The image and appearance of the human body, N.Y. Inter-
national Universities Press, Inc., 1950.

SCHMALE, A. H. and ILKER, H. P.

The affect of hopelessness and the development of cancer.

I, Identification of uterine cervical cancer in women with atypical cytology. Psychosomatic medicine 28 : 714, 1966.

SILVERBERG, W. V.

Childhood experience and personality destiny; a psycho-analytic theory of neurosis. New York, Springer Publishing Co., Inc., 1952.

SONTAG, L. W. et al

Mental growth and personality development : A longitudinal study. Monograph of the Society for Research in Child Development, 23 (2), Serial No 68, 1958.

SYNDERMAN, R. K. and GUTHRIE, R. H.

Reconstruction of the female breast following radical mastectomy. Plastic reconstruction surgery 47 : 565-567, 1971.

SUTHERLAND, A.

Psychological impact of cancer surgery. Public health report 67 : 1139 - 1143, 1952.

SUTHERLAND, A. M., BARD, M. et al

The psychological impact of cancer. A series of articles published originally in Cancer. American cancer society reprint, Code no 3009, Feb., 1974.

THARP, R. G.

Psychological patterning in marriage. Psychological bulletin 60 (2), 97 - 117, 1963.

TOFFLER, A.

Future shock. N.Y. Random House, 1970.

TRACHTENBERG, J. M.

Team involvement and the problems incurred. Presented at 15th annual clinical conference on progress in the rehabilitation of the cancer patient. Houston, Texas, 1970.

TROLL, L. E.

Early and middle adulthood. Monterey, Calif: Brooks/Cole, 1975.

U.S. NATIONAL HEALTH SURVEY

Health interview responses compared with medical records. Series D - 5, Public Health Service, Washington, D.C., June (1961).

VISOTSKY, H. J., HAMBURG, D. A. GROSS, M.E. and LEOVITS, B.Z. Coping behaviour under extreme stress. Arch. gen. psychiat. 5 : 423, 1961.

VOLICER, B. J.

Patients' perceptions of stressful events associated with hospitalisation, Nursing research 23 (3) : 235 - 238, 1974.

VOLKART, E. H.

Bereavement and mental health. In Leighton, A. H., Clausen, J. A. and Wilson, R. N. eds. Social psychiatry. N.Y. Basic Books, 1957.

VOLKART, E. H. and MICHAEL, S. T.

Bereavement and mental health. In Leighton, A.H., Clausen, J.A. and Wilson, R. N. eds. Explorations in social psychiatry, N.Y., Basic Books, 1957.

WAELDER, R.

Basic theory of psychoanalysis. International Universities Press, 1960.

WEINER, J. M.

Reaction of the family to the fatal illness of a child.

In Schoenberg, B., Carr, A.C., Peretz, D. and Kutscher, A. H. eds. Loss and grief : Psychological management in medical practice. N.Y., Columbia Univ. Press, 1970.

WEISMAN, A. D.

On dying and denying. New York, Behavioural Publications Inc., 1972.

WEISMAN, A. D.

The patient with a fatal illness - to tell or not to tell. Journal of the American medical association 201 : 646 - 648, 1967.

WEISMAN, A. D. and HACKETT, T. P.

Denial as a social act. In Levin, S. and Kahana, R. eds. Psychodynamic studies on aging : Creativity, reminiscing, and dying. N.Y., International Universities Press, 1967.

WHITE, ROBERT W.

Strategies of adaptation : An attempt at systematic description. In Coelho, G.V. , Hamburg, D. A. and Adams, J.E. eds. Coping and adaptation. N.Y. Basic Books, 1974.

WRETMARK, G.

A study in grief reactions. Acta. psychiat. neurol. scand. 33 : 292, 1959.

YOUNG, M., BENJAMIN, B. and WALLIS, C.

Mortality of widowers. Lancet (2) ; 454, 1963.