A PORTFOLIO OF STUDY, PRACTICE AND RESEARCH

Coping after Breast Surgery

Submitted for the Doctor of Psychology (Psych D)

in Clinical Psychology

CONVERSION PROGRAMME

By

ANITA HELEN FARRELL
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ACKNOWLEDGEMENTS

My thanks go to many people along the way, too numerous to mention here. Firstly, I must thank all the Dudley Cancer Support Group and all the women who took the time and trouble to participate in this study and who allowed me to impose upon their time. I would like to thank in particular Ann Fellows who was my Research Assistant for her help in the collection of the data. My thanks also to Glynis Laws and Clare Twigger-Ross for their helpful comments and to Lorraine Nanke for her kindness and words of encouragement. For their time and interest I would like to also extend my thanks to Evanthia Lyons and Ian Robbins, my external examiner.

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Previous Submission in partial fulfilment of the Msc in Clinical Psychology
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SECTION ONE: PROFESSIONAL AUDIT
PERSONAL STUDY PLAN

Psych D in Clinical Psychology

Conversion Programme

Name: Anita Helen Farrell

Date of Registration: 04.10.94

Registration Number: 3408981

1. OVERALL AIMS AND OBJECTIVES

Prime Aim

To attain a higher level of professional competence. To investigate and report upon various areas of academic interest and research in Adult Mental Health and Physical Medicine specialisms. This will have a specific focus upon problems that relate to women. Furthermore, to enhance my professional development as a Chartered Clinical Psychologist working in the National Health Service by undertaking an evaluation of a team orientated service for adults with physical problems.

Prime Objective

To produce a portfolio of study, practice and research which will enhance competence in each of these areas.
2. ACADEMIC AUDIT

2.1 Aims:

To demonstrate academic competence in three areas of Clinical Psychology and to enhance the range of professional and clinical expertise available in my Department. To update previous knowledge and to develop and extend knowledge into other areas of interest.

To offer a more informed service within the Adult Mental Health specialism to depressed and alcoholic women. In addition, to aid my understanding of multidisciplinary teamworking and styles of teams in order to be able to make informed choices in future service planning.

2.2 Objectives

To complete three critical academic reviews in three specialist topics. To enhance knowledge and facilitate a greater understanding of these three areas.

To attend various conferences, study days, seminars, courses and training events to enable continuing professional development.

2.3 Rationale

I am interested in all aspects of physical trauma that impinge upon the psychological welfare of women. I need to keep up to date in this area in order to build a sound basis for my clinical work.
The Psychosocial Aspects of Depression in Women

The psychosocial aspects of depression in women is a very relevant topic to my general work. This bridges both my adult mental health work and a more specialised service I also offer to women with physical problems. I would therefore like to refresh my knowledge in this area. This review of women and psychosocial factors influencing depression provides relevant background information to the next critical review on alcoholism in women and is also pertinent to the Research Audit section of the portfolio.

Psychosocial and Other Factors: their Role in Alcoholism in Women

The factors influencing and maintaining alcoholism in women are under reported. Although common, alcohol abuse and dependency remain for most women, a dark and hidden secret of shame. I would like to review this area as I am aware my knowledge is limited in this field. This would help to enhance my clinical work.

A Review of Multidisciplinary Teamworking

The role of multidisciplinary teams is an area that has particular relevance to clinical practice and raises many questions regarding how services are delivered. I would like to investigate this as I have been involved with a new service where team style became an important issue. When the style of team is inappropriate and fails to meet the needs of the service users and team members this can compound the problems of multidisciplinary teamworking. Because this review is relevant it should to be viewed as an important precursor to the Clinical Audit section of the portfolio.
2.4 Plan

Academic Reviews:

1. The Psychosocial Aspects of Depression in Women

To search the literature for articles and papers relevant to the psychosocial aspects of depression. To review the literature relating to depression and the psychosocial factors that can precipitate and maintain depression in women.

To provide a backdrop for the psychosocial aspects of depression to be discussed by outlining the work of previous authors concerning gender issues and pre-existing theories of depression. To categorise the extensive research into three distinct themes or areas within the psychosocial factors of depression. Thus, the areas of major life events, social factors and socio-cultural factors and role conflicts will reviewed. This review aims to examine these three major psychosocial themes or areas influencing depression. In addition, the attention will be drawn to the paucity of literature that discusses depression in men.

2. Psychosocial and Other Factors: their Role in Alcoholism in Women

To search for and review the literature focusing on the psychosocial and other factors that influence why some women become alcoholics and why their behaviour is maintained. Attention is given to the need to identify sub-groups of women alcoholics and the lack of studies that address the psychosocial issues operational for men.
To provide a comparison between men and women the gender differences will be reviewed. Past studies of the aetiological factors of alcoholism in women will be searched for and discussed. The psychosocial aspects of alcoholism will be searched for, investigated and reported, as will the different roles of women in western society and how this may have a contributory part in precipitating and maintaining alcoholism in women. There will be a search of the literature regarding various sub-groups of women who may have specific problems relating to alcoholism such as sexual abuse, sexual orientation, ethnic minorities and family background and these will be reviewed and reported.

3. A Review of Multidisiplinary Teamworking

To search the literature in order to review multidisciplinary teamworking and the styles of team that exist. The advantages and disadvantages of multidisciplinary teamworking will be investigated in the literature. Different kinds of problems in teamworking may be found dependant upon the style of team that is operational. Therefore, information will be sought regarding the different styles of team that generally exist.

The different styles of team will be reviewed and discussed to highlight the common problems found in teamworking. This review may be viewed as the precursor to the subject of establishing a new team-based service chosen for discussion in the Clinical Audit.
3. CLINICAL AUDIT

3.1 Aim:

To increase my professional competence by further developing my skills in reporting on the evaluation and provision of services. To understand and learn from my past experiences of helping to set up a new and innovative service. To become more aware of what can go wrong and have the relevant academic underpinning in order to make sense of the problems. This will provide invaluable managerial insights that will help me in the future to implement, develop and maintain a service for which I may be responsible.

3.2 Objectives

To present a report on the difficulties of implementing a new and innovative multidisciplinary team service to the community.

To examine the difficulties in detail, diagnose the problems and develop a way forward.

To make recommendations and issues for consideration regarding change.

To make considered recommendations about the setting up of the service in an adjoining geographic area.

3.3 Rationale

I was interested to write this report because of my past experiences of working in teams of various descriptions. This particular team suffered many setbacks as it struggled to assert
itself as a therapist driven, medically supported team. Furthermore, the team experienced
difficulties with one member taking control of the team. This lead to role conflict,
disharmony and the eventual loss of some team members to other less stressful posts.

3.4 Plan

An overview of the service and it’s geographic location will place the service within
context. The difficulties encountered in introducing a new concept of care into a traditional
management structure will be highlighted. The key issues will be laid bare and discussed
with respect to the business planning of the service, management style, style of team,
organisational difficulties and the difficulties of working in a multidisciplinary team setting.
The way the team attempted to resolve the problems was via meetings and workshops
which will be researched from an organisational approach.

Considerations for change will be proposed. Some problems will be highlighted and how
they might be resolved, in particular the team conflict that emerged will be researched.
Consideration will also be given to the eventual expansion of the service into an adjoining
district.

Ongoing Professional Development:

The following courses have been attended since the inception of the Doctoral programme
in October 1994. My aim was to enhance my professional development in a number of
areas relevant to my work. Some were clinically based courses aimed at improving my
understanding of various topics that relate to my clinical work. Other courses attended
have been directly related to the increasing management role I have within the post I currently hold.


CCMS Course Project: The differences between Counsellors and Clinical Psychologists

CCMS Course Presentation: Teaching Relaxation Techniques

Attendance at the 1995 Introduction to Supervision of Clinical Psychology Trainees Course (1 day) University of Birmingham.

Attendance at the 1995 Supervisors Workshop (2 days) for the Doctorate in Clinical Psychology Course, University of Birmingham.

Attendance at the 1996 Supervisors Workshop (2 days) for the Doctorate in Clinical Psychology Course, University of Birmingham.

Attendance at the 1997 Supervisors Workshop (2 days) for the Doctorate in Clinical Psychology Course, University of Birmingham.

Attendance at a Recruitment and Selection Course (1 day), Dudley Priority Health Trust.

Attendance at an Equal Opportunities Course (1/2 day), Dudley Priority Health Trust.

Attendance at monthly Professional Development Meetings, Dudley Priority Health Trust:
Topics covered: Sexual Abuse/ Cancer/ Victim Support/ HIV and AIDS/ Self Harm/ Reporting Child Abuse/ Accreditation for Counsellors

Attendance at the Black Country Consortia Study Days:

Topics include: Risk Assessment/ Neurological Assessment skills/ Post Traumatic Stress Syndrome/ Personality Disorders

Personality Disorders Workshop, June 1997.

The White Hart Professional and Management Development Course, (part-time, 3 modules during 9 months), Harrogate, Yorkshire:


The White Hart Professional and Management Development Course Project: Guidelines for the Employment of Counsellors in NHS settings

Selection Skills for Interviewers, (1 day), Dudley Priority Health.
4. RESEARCH AUDIT

4.1 Aims

To enhance my understanding of the problems experienced by women following breast surgery. To become more aware of the difficulties they experience, thus adding to my clinical expertise in treating women who have undergone such surgical procedures.

To further develop the services offered in my department and to enhance my own professional clinical skills.

4.2 Objectives

To present evidence of professional competence by undertaking research within my clinical practise that is underpinned by theory. To use a multi-methodological approach to broaden and strengthen the clinical picture that emerges from the data.

4.3 Rationale

My interest in the psychological consequences mastectomy has extended over a number of years. Within my current practice I offer a service for women with an emphasis on physical health problems.

How women cope with the consequences of surgery, both physically and emotionally are to be addressed in this study. Particular attention is paid to the problems, their long term
nature and the factors that continue post-operatively to contribute to psychological distress.

A comparison will be made concerning the differences between mastectomy compared to lumpectomy with a specific interest in coping styles and other relevant factors. In addition, the problems that revolve around having a compromised body image are highlighted. How women cope with such traumatic surgery and some of the compounding influences acting upon them are discussed with particular attention being given to treatment processes such as radiotherapy and follow-up sessions with surgeons and oncologists.

4.4 Plan

A review of the known problems of post-mastectomy trauma such as psychological morbidity, anxiety, depression, age factors, marital status, loss of femininity and issues relating to body image will be reported upon. Attention is also given to the processes of treatment with an emphasis on their experiences of pre-operative treatment, helpful and unhelpful experiences, radiotherapy and follow-up sessions with their Consultant.

Validated questionnaires will be used to measure depression, anxiety, personality factors, marital satisfaction, the impact of the event, self esteem, general distress and with particular emphasis on ways of coping. Part of the work will revolve around facilitating respondents to tell of their experiences via individual semi-structured interviews. It is hoped that this will highlight the factors that continue to act as stressors for women long after surgical intervention.
5. PORTFOLIO OUTLINE

SECTION ONE: ACADEMIC AUDIT

Critical Review One: The Psychosocial Aspects of Depression in Women

Critical Review Two: Psychosocial and Other Factors: their Role in Alcoholism in Women

Critical Review Three: A Review of Multi-disciplinary Teamworking

SECTION TWO: CLINICAL AUDIT

The Establishment of a New Reablement Service

SECTION THREE: RESEARCH AUDIT

Research report examining the long term consequences of mastectomy entitled: Coping after Breast Surgery

SECTION TWO: ACADEMIC AUDIT
CRITICAL REVIEW ONE:

The Psychosocial Aspects of Depression in Women

Depression can be generally characterised by a sense of inadequacy, despondency, decrease in activity and reactivity, pessimism, sadness and other related symptoms. The term describes a cluster of symptoms that comprise lowered mood, anxiety, sleep disturbance, loss of interest and energy, poor appetite and often includes suicidal ideation (Rippere, 1987). It is suggested here that this formula encompasses the main characteristics of depression but is an inadequate shorthand for this complexity of psychological states. Most individuals could claim to suffer from depression during their lifetime. However, when these characteristics of depression are extreme and intense, they are regarded as symptoms of psychological disturbance or a specific depressive disorder.

Historically there has been much controversy regarding the classification and definition of depression. From a medical model perspective there has been a focus upon the physical presentation of depression, the biological background and causes such as genetic predisposition. Whilst this is valuable and has lead to some effective drug treatments such classifications have left little room for a definition of depression that manifests from psychological and social factors. It can be said that the more severe the disturbance in biological processes the greater the impairment to psychological and social functioning. However, the causal factors are not clear and may be reflecting an interaction between physical, biological presentations and psychosocial influences.

The focus of this paper rests upon the psychosocial factors that can precipitate, contribute to or cause depression in women. The material has been primarily drawn to display the development of research in Western society over recent years, with reference to earlier classic studies. To provide a backdrop that illuminates the psychosocial aspects of depression other theoretical perspectives and gender differences will be briefly discussed. It is the contention of this review
that the psychosocial factors effecting men may well be different to those that affect women. Indeed, the expression of depression in men may differ to that of women. Thus, gender comparisons may formulate the main thrust of research in the future. It is argued here that no one model or school of thought can explain the cause of depression in women and that psychosocial factors have a very important part to play in the precipitation, maintenance and recurrence of depression.

It is noted that various schools of thought, such as the feminist movement, generate little supportive empirical evidence which makes them difficult to evaluate. In addition, the problems of reviewing literature in this area are clear in the vastness of the research. Despite the profusion of literature, there has been no attempt, as yet, to integrate theories across different levels of analysis.

In summary, the presentation of incompatible theories, ranging from the reductionist biological perspective to the social viewpoint, explain well from their different orientations. However, they fail to demonstrate the overlapping and interacting nature of theories or models of depression. Furthermore, treatment alone cannot address the social issues. It is argued here that it may be helpful to take an integrated, holistic and multidisciplinary approach to care, in order to bring about change.

Gender Differences
A study by Klerman (1988) reported increased risk and rate of depression in individuals born after World War II, the "babyboomers". Although, there is no acknowledgement that professionals today are more adept at identifying depression, she noted higher rates of depression in women “babyboomers” compared to men. Indeed, incidence rates of depression have been well documented and it is generally agreed that women are more vulnerable to depression than men (Kessler, Mc Gonagle, Swartz, Blazer & Nelson, 1993; Thase, Reynolds, Frank, Simons, Mc Geary, Fasiczha, Garamoni, Jennings & Kupfer, 1994). This contention is
further supported by Spaner, Bland & Newman (1994) who reported major depressive disorder affecting more women than men by a ratio of 2:1.

However, Nolen-Hoeksonma and Girgus (1994) report no gender differences in depression until the age of 15 years. They propose that depression has a cultural and social cause in both sexes, but, becomes more prevalent in adolescent girls. They argue that girls and boys develop risk factors for depression in childhood but face more challenges than boys in adolescence. This idea receives further support from Kessler, McGonagle, Zhao, Nelson, Hughes, Eshelman, Witchen & Kendler (1993). These authors reported an earlier age of onset for depression in adolescent girls than boys. Thase et al (1994) provided similar evidence of gender-specific differences.

In summary, because of the dearth of literature in this field further research is needed. Specifically this would be useful into pre-adolescent risk factors and gender specific differences, and how they relate to psycho-social factors for both sexes. Further research is also needed into how to help relieve depression that may be being expressed differently according to sex and gender specific psychosocial factors.

Theories and Models of Depression
No discussion is complete without reference to pre-existing theories of depression. From a medical perspective, depression is viewed as an illness caused by an imbalance of chemicals in the brain (Lickey and Gordon, 1983). It has been helpful for depression to be considered as an "illness", so that it has been taken seriously. However, this has led to stigmatisation of sufferers (Goffman, 1963).

Nairne and Smith (1984) argued that although the medical model of depression as an illness has strengths in treatment of depressive states, it is rooted in a biological explanation of what is essentially a psychological and social phenomena. On the other hand, the efficacy of antidepressants has demonstrated the value of the medical approach in dealing with depression.
It has become widely accepted that biological factors can have a critical bearing upon mood; this has been clearly demonstrated in the extensive literature on depression in women concerning menstruation, post-partum and menopause. These times of hormonal and biological changes in women create considerable topical interest but they cannot alone be responsible for the high incidence rate of depression in women rather than men (Weissman and Paykel, 1974). These authors draw attention to the social, cultural and environmental factors that can interact with hormonal and biological pre-disposition precipitating depression.

A more sympathetic approach to the treatment of depression is arguably from a psychological perspective. Freud in his landmark text "Mourning and Melancholia" (1918), centred his argument on loss being central to depression. The biological element of his loss theory also offers limited explanation of sex differences. Freud proposed that depression is caused by women's lack of male genitalia, leading to women's feelings of inferiority, jealousy and penis envy. This hinges upon the concept of male power and domination over women, who direct their hostility towards themselves, resulting in depression. This theory has been criticised for its over-concern with male interpretations of female experience (Nairne and Smith, 1984).

More recently, Seligman (1978) proposed a model of "learned helplessness", based upon animal experiments, which may be regarded as an analogy of human behaviour. Depression is seen as resulting from a lack perceived control and positive reinforcement. In his theoretical orientation lies the work of behavioural psychologists, who attempt to alter behaviour in order to bring about change. The notion generated from his work suggests that helplessness is a learned response to the lives' women have, leading to feelings of despondency and depression. This model can be an effective form of intervention, however, it is generally considered to be too simplistic as it does not take into account feelings, thoughts or past experiences (Nairne and Smith, 1984).
Beck, Rush, Shaw & Emery (1979) pinpointed the relationship between behaviour and thought processes in cognitive-behavioural therapy. This theory rests on the claim that depression results from negative thoughts and perceptions. Distorted thought processes lead to negative expectations. Thus, depression activates negative schemata that govern information processing. Beck et al. described the cognitive triad of self, world and future that are influenced by negative information processing. Both Seligman and Beck's ideas are based on learning theory that offers some opportunity for change in thinking and behaviour. Neither theory takes account of past experience, social and cultural factors.

A study by Dent and Teasdale (1988) investigated depression in middle-aged women, they found that women who had negative thinking were slower to recover from depression than women who had more positive thoughts about themselves. Ingham, Kreitman, Miller, Sashidharan & Surtees (1987) linked vulnerability to depression with negative thoughts and appraisals of self. They found high self esteem a protective factor from further episodes of depression.

Therefore, it is argued here that psychological approaches are primarily limited by a lack of consideration of biological differences and social factors. These approaches can offer treatment models but can offer no explanation of depression in a wider cultural or social context.

**Psychosocial Factors in Depression**

Empirical research has focused on the development and refinement of treatment for depression. Such studies have also offered some understanding of the aetiology of depression in women. The first major study, taking a wider epidemiological perspective, was conducted by Brown and Harris (1978). For reasons of convenience, women were used as subjects in this landmark sociological study aimed at finding out how social factors play an important part in depression.
This study viewed depression as largely a social phenomenon, uncovering a vast area of loneliness and isolation within the family circle. Subjects were from a rural background (the Hebrides) and compared with subjects from an inner city area (Camberwell, London). The authors developed a model that helps to clarify the aetiology of depression in women. The model is based on three interactive components: a) provoking agents, b) vulnerability and c) symptom-formation factors. Overall, their findings reveal that low social class, traumatic life events, financial difficulties, housing problems and lack of a close confidante, predispose women to depression.

Brown and Harris suggested that having an intimate relationship, employment, a religious commitment and less than three children at home reduced the risk of depression. Some criticisms have been levelled at this seminal study. There is no discussion of how their findings compare to depression in men and it is argued here that a similar study of depression in men is warranted. The study was not conducted to gain understanding of women and depression as a women-only sample was used for reasons of convenience (Nairne and Smith, 1984). Furthermore, it is now almost twenty years since the study was published which may make some of the findings outdated.

Because of the extensive literature concerning psychosocial factors, it is necessary to categorise this research into two distinct areas, which are not mutually exclusive.

(a) Major Life Events
Al-Issa (1980) examined marriage in relation to men and women. She found that women were more likely to be depressed after a divorce, separation or death of a spouse. Kaplan (1986) highlighted the impact of life events and their role in depression and increased risk of suicide in women. She stressed that retirement, death of a spouse or first degree relative (Scott, Barker & Eccleston, 1988) can precipitate depression. Corney (1987) also offered evidence of marital difficulties as a major life stressor contributing to depression. Corney reported greater financial difficulties for women than men following the breakdown of the marital relationship.
Other life stressors are more specific to women's experience. Newsatter and Newson (1986) studied women following an abortion. They highlighted how some women are "bullied" into seeking abortions because of societal attitudes. Depression rates rose higher if the abortion precipitated the breakdown of their intimate relationship. Pipes (1986) drew attention to societal disapproval of abortion and how women often live with this as a guilty secret, creating inner conflict, leading to depression.

Post-partum depression often follows the life event of childbirth. Hobfoll and Lieberman (1987) interviewed women after childbirth and followed them up three months later, finding women with low self-esteem being more likely to be depressed. Glover, Liddle, Taylor, Adams & Sandler (1994), associated hypomania following childbirth with a higher risk of depression, with Prettyman, Cordle & Cook (1993), demonstrating a 6% increase in depression following miscarriage.

Furthermore, Harris, Ellicott & Holmes (1986), showed how personal disruption often coincides with biological changes, such as menopause, greatly increasing depression rates. Hay, Bancroft & Johnstone (1994), associate depression with the "peri-menopausal period" (4 years before and after menopause), linking this to stressful life events such as children leaving home.

Renvoize (1982) highlighted past sexual abuse with higher depressive rates in women. Kuyken and Brewin (1994) argued that intrusive thoughts of past sexual abuse increased depression. This was supported by Pope, Mangweth, Negrao, Hudson & Cordas (1994) whose study found depression related to sexual abuse rather than to other factors such as the eating disorder of bulimia. Monroe, Bromet, Melanie & Steiner (1986) predicted depression in women following a major life event with Cole (1990) relating physical illness to depression and Shalev (1993) linking depression to biological disturbance evident in post traumatic stress syndrome.
In summary, these studies demonstrate an association between particular life events and depression in women, but, cannot explain why some women become depressed following such events and some do not. Also, there are no comparative studies to men, therefore, research is needed into how men experience major life events.

(b) Social Factors

Oakley (1974) saw the relevance of social roles, such as being a housewife, to increased depression rates. Belle (1982) linked depression to low income, lack of opportunities, poor housing and unemployment. The authors pointed to a lack of control or mastery in life as a central component of depression in women. This stressful position created anxiety that leads to depression over time. Pattison and Kaufman (1982) revealed how compounded problems led to feelings of guilt, shame and self-criticism. These negative attributes interacted with the social expectation that women should be nurturing and self-deprecating creating a propensity for depression.

Grist (1986) commented that women are trained from early childhood to be submissive, selfless, nurturing, caring and not to show aggression thus denying women an outlet for their negative emotions. Grist stated that relationship pressures tend to emotionally isolate women from their partners. The role men have in applying pressure to encourage negative attributes in women was also stressed by this researcher. However, Grist made no comment about the way in which women also reinforce these negative attributes themselves which is clear in the work of Hops, Biglan, Sherman, Arthur, Friedman & Osteen (1987). Hops et al offered the first evidence that depressed mothers behave differently towards their children than non-depressed women. They suggested that female children learn depressed behaviour from their mothers.

The social problems and ratio of depression in older people have also risen. This is because of the very numbers of individuals living to a greater age. A study of an elderly Chinese population by Woo, Ho, Lau, Yuen, Chiu, Lee & Chi (1994) highlighted the social difficulties of the elderly. Woo et al indicated that poor health, memory and sensory deficits, combined
with infrequent family contact and lack of a carer, increased the risk of depression. However, in a critical review of the research (Cole, 1990) serious methodological flaws were found with many studies of depression in the elderly. Future research needs better design, methods, outcome measures, control of extraneous factors and careful selection of study populations.

Weissman and Paykel (1974) identified role conflicts created by Western culture. Part of a larger study, they found evidence of the cultural problems experienced by women. They report more demands on women in terms of social, family, employment, marital and parental responsibilities. This balancing act lead to role conflicts as each role competed for energy and time. The work of Weissman and Paykel has gained much support from other authors. Gordon and Ledray (1985) illustrated how therapeutic intervention can reinforce female stereotypes in Western culture. Baucom and Weiss (1986) sought to determine the degree of control women have with different sex role identities. These authors discuss their findings in relation to learned helplessness theory and, in this context, aided the understanding of depression in women. They found that women having masculine rather than feminine traits were more likely to be offered creative tasks at work than women rated as being feminine.

Gleve (1987) argued that the Western role of mother is challenging to the self-identity of women because it combines a lack of reward or achievement within a culturally bound low evaluation of childrearing. Nonetheless, Baruch and Barnett (1986) say that this is redeemable if women are in paid work, thereby balancing the positive and negative attributes perceived culturally by women themselves. However, research is needed comparing Western women with those of other cultures.

Kaplan (1983) suggested that depression is not an illness but a distortion of the female state that is culturally bound by the inhibition of assertiveness and anger. The "Selflessness Syndrome" (Lemkau and Landau, 1986) is the notion that women have socially reinforced idealised beliefs that encourage self-denial and striving for satisfaction through vicarious means. Women, therefore, become depressed because of social expectations and definitions of
femininity that their own culture imposes. It is argued here that this social inhibition of self worth and expression creates low self-esteem, predisposing women to depression. Arguably, learned helplessness is the mechanism through which these beliefs are mediated.

Within any culture minority groups are often stigmatised. Richardson (1987) reported on the social consequences and stigmatisation of women AIDS sufferers and HIV positive women. In Western culture, these women are "social lepers", becoming socially isolated by their illness and, thereby, increasing their propensity to depression. Ross (1994) suggested that the stigma of being female and overweight created an internalisation of a negative self-concept, especially in well-educated groups who equate attractiveness with being thin. This raises the question whether well-educated overweight women are more vulnerable to depression because they feel devalued by society. Warren (1994) showed how Afro-American women are devalued in society by virtue of being black. Whilst Cochrane and Mays (1994) reported significantly more Afro-American women who were homosexual being depressed than male homosexuals.

In summarising, the relevance of social roles and expectations for women needs further exploration using better comparative research methods. It is argued here that minority groups within any society are more likely to suffer from depression. Cultural ideas, notions and social expectations need to change to accommodate such minority groups. The question is also raised whether men have similar difficulties that are not recognised socially and hence, ignored.

Conclusion

It would appear that, despite the extensive literature, research into the psychosocial factors of depression in women is as yet incomplete. Currently, the various theories and models are competing from differing perspectives, however, each may be representing different levels of analyses. Future research needs to address the links between the various models of depression and work towards a clear unifying theoretical perspective.
Further research is also warranted into minority groups, how women may be reinforcing negative social expectations and cross-cultural studies of women. Similarly, research into early risk factors and learnt depressive behaviour could be effective in identifying those most at risk from depression. In fairness to men, there is well-documented evidence of psychosocial factors affecting women but a dearth of literature about depression in men. The lack of consideration of such gender differences as well as biological and social factors limits the effectiveness of medical and psychological approaches to treatment and care. However, with recent moves towards multi-agency and multi-disciplinary working, professionals are now better positioned to bring about a more holistic approach to care that may encompass psychological treatments and changing of social circumstances.

Thus, this review has highlighted the profusion of literature from many perspectives on this subject. It has demonstrated the need for further research in some areas such as comparative studies with men. It has also drawn attention to the need future studies of the on the integration of models, theories, schools of thought and treatments that will provide a more holistic approach to the common problem of depression.
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CRITICAL REVIEW TWO:

Psychosocial and Other Factors and their Role in Alcoholism and Women

A Definition of Alcoholism

The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV, 1994) specifies the diagnostic features of substance abuse and dependency that incorporates excess alcohol consumption. Alcohol dependency using these criteria is defined as the maladaptive pattern of alcohol use, leading to clinically significant impairment or distress with markedly increased amounts of alcohol needed to achieve intoxication. The continued use of alcohol is consumed to relieve or avoid the symptoms of alcohol withdrawal (insomnia, anxiety, autonomic activity, etc.).

This review seeks to examine the literature regarding psychosocial and other factors and their role in alcohol dependency and abuse by women. The prevalence of alcoholism in women and the gender differences that exist are discussed. The aetiology of alcoholism and the role of psychosocial factors such as life events, role conflicts, stressors, psychiatric morbidity and affect are also discussed. Attention is drawn to the methodological difficulties in past research such as treating all women alcoholics as a homogenous group and the male-as-norm bias (Wilke, 1994). This has influenced research and treatment of women alcoholics. The need to identify and study subgroups of both men and women drinkers and their patterns of drinking is emphasised. It is argued here that a sea change in the theories and research into alcoholism is therefore long overdue.

Prevalence of Alcoholism

In western culture drinking alcohol to excess has consistently been regarded as more acceptable amongst males than females. This may account for the many women who do not come to the attention of services and voluntary agencies such as Alcoholics
Anonymous (Gomberg, 1993, Dunne, Galatopoulos & Schipperheijn 1993). Although, Chappel (1993) reported an increase in women members of this organisation.

Oppenheimer (1991) indicated the extent of the problem in women, reporting that in the United States of America (U.S.A) one-third of all alcohol abusers were women. This author estimated that 1% of women in the United Kingdom (UK) were also abusing alcohol. Although, a more recent study of general population surveys by Wilsnack and Wilsnack (1995) reported the number of women in the U.S.A abusing alcohol had decreased in comparison to the 1980's.

Shaw (1980) reported that in the UK more men than women suffer deaths due to liver cirrhosis commonly associated with alcohol abuse. Moreover, alcoholic men also tend to meet deaths indirectly attributable to alcohol abuse such as suicide in the UK (Breeze, 1986). However, the seriousness of the problem for women is reflected in high death rates reported in Finland due to alcohol psychosis (Perola, Vuori & Pentilla, 1994). Perola et al (1994) pointed out that death due to alcoholism is still greatly under-reported. Even in known cases of chronic drinking, death certificates mentioned alcohol related diseases in less than 50% of cases. This finding was reflected in a study conducted in the U.S.A (Gupta, 1993) who found under-reporting of deaths attributable to alcoholism were particularly evident in either sex aged 65 years and over.

Gender Differences in Alcoholics

Past research by Shaw (1980) noted a progressive and increasing trend during the 1970s for women to be diagnosed as alcoholic, compared to men. Shaw reported that over a ten year period women diagnosed as alcoholics increased threefold compared to male alcoholics, who increased twofold over the same time span. The Avon Council on Alcoholism (1982) also noted a similar increase of 39% of women abusing alcohol over
the same ten year period. This increase was shown in clinical studies, which indicated a growing number of women were admitted to psychiatric units for alcohol related difficulties (Breeze, 1986). The ratio of men to women with alcohol related illness has also changed. Breeze (1986) suggested that this was apparent in the significant increase in female admissions where alcohol was a central feature in their reason for admission.

Much of the literature investigating the causes of alcoholism support a tendency for women alcoholics to be more influenced by their moods than men alcoholics. There is wide agreement that women alcoholics were more likely to initiate periods of drinking when they were stressed, anxious, lonely or experiencing feelings of inferiority or social isolation than men (Lindbeck, 1972; Beckman, 1975). McConville (1983) indicated that women alcoholics frequently cited feelings of shyness, anxiety, inadequacy, depression, boredom, frustration and lack of confidence as reasons for their excessive drinking. Similarly, Olenick and Chambers (1991) reported that women alcoholics used alcohol to alter their mood state more than alcoholic men. When feeling stressed, anxious or depressed these women were more likely to drink to excess in an attempt to combat these feelings and thereby raise their mood.

More recently Lancaster (1994) discussed gender differences in the brains of male and female alcoholics. Lancaster argued that differences can be seen between male and female alcoholics in the different effect alcohol has upon neurochemicals in the brain. In particular levels and activity of neurosteroids in the brain may be responsible for these differences. However, the influence of alcohol on the glial cell production of such neurosteroids may also explain gender differences. As Lancaster stated, clarification is yet to be achieved by future research. Therefore, if neurochemical responses to alcohol are determined by gender this would give rise to differences in behaviour. However, without studies of gender differences comparing the brains of alcoholic men and women with a normal population, it is difficult to support such a contention.
Wilke (1994) commented upon the male-as-norm bias that pervades research, assessment and treatment and how this has shaped perceptions of women’s alcoholic behaviour. Therefore, differences that exist between men and women alcoholics were often minimised or ignored in treatment. Ravndal and Vaglum (1994) and Burman (1994) indicate that teasing out the gender differences would be valuable in the development of treatment programmes. This is because most treatments have been based on research conducted with men (Quinby and Graham, 1993).

In summary, evidence that women alcoholics report a greater influence of psychosocial factors upon their drinking than men is of significant interest. However, the underpinning theoretical perspective concerning why this seems to be a more common scenario in women remains unclear.

The Aetiological and Psychosocial Factors of Alcoholism in Women

Although biological and genetic factors may have a role in the aetiology of women’s drinking problems, the most frequently implicated cause of alcoholism in women are psychosocial factors. It is argued here that psychosocial factors have a role in the aetiology of alcoholism in women. Indeed, psychosocial factors may not only precipitate alcoholism but also serve to maintain it. This may also be true for men. However, this review has primarily focused on the psychosocial factors operational for women.

As Wilkie (1994) has highlighted the male-as-norm bias has led to a greater understanding of alcoholism in men than women. Much is now known about the familial patterns of alcoholism and the aetiological factors that can precipitate alcohol abuse for men. Currently there is a lack of evidence in the literature concerning these factors in women, although there is one study that has highlighted these aspects for women. The aetiological factors of alcoholism in women have recently been investigated by Hill (1995). This author argued that for some women alcoholism is a genetically mediated disorder influenced by cultural, environmental, familial and personal characteristics. The salient personal characteristics Hill identified moderating genetic vulnerability include age, ethnicity and
psychiatric co-morbidity. It was proposed by Hill that two forms of alcoholism may exist; genetically determined alcoholism and an environmentally determined alcoholism due to cultural and familial factors. Hill also argued that the interaction between genetic vulnerability and environmental factors will never be clear.

In the seminal work of Brown and Harris (1978) the psychosocial factors of depression in women were uncovered. These authors made an important contribution to the understanding of psychosocial factors that may have a precipitating and maintaining role in alcoholism. It would appear that the combined effects of psychosocial factors make women's lives stressful, the excessive use of alcohol may be a maladaptive way that some women cope with the stress of their lives. However, this raises the question why some women become alcoholics and others with similar stresses do not, which cannot be explained by this model.

Psychosocial problems such as marital and relationship difficulties have been cited as the cause for some women to drink to excess (Schuckit and Morrissey, 1976). This study revealed a direct link between marital stress and the onset of alcoholism in women. This has received support from Lammers, Schippers & van der Staak (1995) who concluded that some women may use alcohol as a way of coping with a relationship within which they feel powerless.

Lindbeck (1972), drew attention to the high incidence rates of divorce and separation in alcoholic women rather than alcoholic men. Women in this study frequently reported that marriage had been a disappointing and emotionally painful experience. In a review of the literature Schuckit (1972) suggested that as many as two-thirds of women with alcohol problems were divorced or separated. However, it is not clear from this research whether or not the women had problems with alcoholism prior to the separation or divorce. Moreover, if their drinking was a primary causal factor in the breakdown of the marriage. A recent study by Nixen, Tivis & Parsons (1992) suggested that in some respects men and
women alcoholics were similar in sharing a deficit of interpersonal skills that create relationship difficulties.

The onset of alcoholism in women may be related to more than one of the stressors identified by Brown and Harris (1978). In an earlier study Sclare (1970) found that multiple stress factors were operational for many women drinkers. The most commonly reported stressor was marital discord followed by domestic and economic stress. In addition, McConville (1983) also reported financial worries as a central aspect of stress in these women. McConville also suggested that housing problems, and the restraints placed upon women by their families were common stressors for women drinkers. Still, it is not clear why some women seek out alcohol as a coping device when under stress and other women do not.

In summary, the link between genetic predisposition and psychosocial factors in alcoholism may never be clarified. It may transpire that alcoholism has its roots in psychosocial factors for some women. The dearth of comparative studies with males is also noted, research in this area could make a significant contribution to the current literature.

The Roles of Women and Alcoholism

The role women have in western society has changed radically over the last fifty years. Women today have many conflicting roles such as wife and mother, as well as a career. Often these roles are not compatible with one another. In an early study Keil (1978) pointed to the correlation between women undertaking multiple roles and the increased likelihood of alcoholism compared to women who had single roles such as that of a housewife. Shaw (1980) reported on the demands of responsibility and competition in the workplace that placed further stress on women who had family commitments. Shaw predicted that the risk for stress in women would increase as their multiple roles increased.

Parker and Harford (1992) stated that women who have high expectations of themselves both at home and in the workplace, are more likely to have drinking problems. Although,
doubts concerning the oversimplification of such theories are raised because they do not consider the complexity of women’s lives (Wilsnack and Wilsnack, 1992). These authors argued that past research had not addressed the interactive effects of work, family and other aspects of women’s lives. Wilsnack and Wilsnack argued that many interacting variables can increase or reduce the likelihood of problem drinking such as environmental, social and cultural factors.

Because the complexity of women’s lives has increased, the traditional role of the housewife is being devalued (Oakley, 1974). Arguably, women are more likely to experience role confusion today than ever before as they try to balance the demands of family, home and work. Scida and Vannicelli (1978) focused attention on the traditional feminine personality characteristics associated with the role of wife and mother. They showed how this came into conflict with the desire to achieve academic and career success that are traditionally masculine characteristics. Their study hypothesised that some women may become alcoholics as they seek to reduce the conflict between these opposing sets of characteristics, suggesting higher risks in women who combine work with childrearing. Furthermore, Burman (1994) noted that the impact of role conflict upon recovering women alcoholics who have been socialised into dependent and subordinate roles, may explain high relapse rates. As women increase their own means of financial independence, the traditional male role of breadwinner is then challenged. Marital conflict may follow leading to excessive drinking as a coping strategy. Further research into traditional roles and stereotypes and how they are changing is needed.

Broverman, Broverman, Clarkson, Rosenkrantz & Vogel (1970) had earlier indicated how stereotypic male traits are more positively viewed than stereotypic female traits. Their study revealed the pervasive nature of these sexual stereotypes. They found that even amongst clinicians different concepts of health were apparent that correlated highly with these stereotypes. Furthermore, stereotypic male characteristics were rated more favourably than female attributes. Men were regarded as being more healthy, mature,
competent and socially desirable than women. This raises questions regarding how women alcoholics relate to male clinicians who may be in control of their treatment.

It is argued here that the demands of modern life, high expectations, combined with multiple roles may be significantly related to alcoholism in some women. Again, the multiple roles of men as breadwinner, father and partner have not been studied or compared with that of women so how men cope with such role conflicts is yet to be investigated.

Sub-groups of Women Alcoholics

Few studies to date have distinguished between subgroups of women alcoholics. Although there is less literature concerning subgroups, emerging from the research are the first studies of this kind. To date these have been primarily in the area of sexual abuse and its relationship to alcoholism in women.

Over the last five years there has been a gathering of evidence about the impact of sexual abuse or victimisation and alcoholism in women. Hurley (1991) reviewed the relationship between incest and alcoholism finding that this raised questions about the reason why some incest victims become alcoholic and some do not. Windle, Windle, Scheidt & Miller (1995) reported past sexual and physical abuse as being higher in women alcoholics than alcoholic men. On the other hand, Widom, Ireland & Glynn (1995) contended that this is not clear cut and is more complex than had been previously realised. These authors found no significant relationship between childhood abuse and subsequent alcohol abuse in men, however, past sexual abuse was found to be related to alcoholism in women. Sexual abuse and violence in childhood are argued as predictors of later alcohol problems by Beckman and Ackerman, (1995). Indeed, similar findings had been evident in earlier work by Bergman and Brismar (1992) who focused their research on familial background, violence and alcoholism. Their findings indicated that violence and alcoholism in the home was predictive of similar problems in the next generation of family members.
An early study of a homosexual subgroup of alcoholic women by Hawkins (1976), revealed the specific problems experienced by lesbian alcoholics. This subgroup of women reported feelings of alienation because of their sexual orientation that led to drinking to excess. Alcoholism was possibly a way of contending with their psychosocial difficulties. In 1987, the Camberwell Council on Alcoholism reported that lesbians are a high risk group for depression and alcoholism because of their perceived social unacceptability.

Pattinson and Kaufman (1982) gave an overview of a subgroup of women alcoholics with an affective disorder. Their review focused on psychosocial factors as a major source of distress creating problems such as alcoholism. The compounding effect of depression and alcohol abuse is discussed in terms of the negative psychosocial consequences alcoholism has on women. They reported that coping with the psychosocial difficulties created depression and consequently alcoholism in some women. This led to feelings of guilt, shame and self-criticism that, in turn, led to further drinking, a difficult cycle of self-abuse to break.

The role of anxiety and depression is unclear in alcoholism but may indicate one or more subgroups of women alcoholics. Gomberg (1993) pointed to a history of depression as being one of the major antecedents for alcoholism in women. The complexity of alcoholism and anxiety disorders is also discussed by Brady and Lydiard (1993) who observed that various anxiety disorders have differing associations with alcoholism. Nixon and Glenns (1995) showed how generally women alcoholics are more frequently labelled with a psychiatric diagnosis than males. Yet, they also highlighted the similarities across subgroups of alcoholics, such as psychosocial variables that can affect either sex. Heikkinen, Aro, Henriksson, Isometsa, Sarna, Kuoppasalmi & Lonnqvist (1994) as part of their study compared depressed women with depressed alcoholic women. Unlike the depressed women, alcoholic women reportedly had continuing problems with stressful life events. These problems had not diminished with age or over time. However, it is not clear whether these continued problems were also related to their continued alcohol problems.
Duberstein, Conwell & Caine (1993) investigated another subgroup of women having a high suicide risk related with alcoholism and other kinds of substance abuse. Their study of this subgroup reveals that suicide in alcoholic women is often preceded by arguments, conflicts and attachment disruptions in the six weeks prior to their death. Klatsky and Armstrong (1993) reported on the need for effective preventative measures to be taken with women considered to be in a high risk category. Arguably, the subgroup of women alcoholics who are deemed a high suicide risk need further research.

Wilsnack (1982) comments that most of the research into women alcoholics has been conducted on middle class, middle aged, white women. Therefore, there is little literature concerning subgroups such as ethnic minorities (Edwards, Thurman & Beauvais, 1995), younger alcoholic women (Donald, Dunne & Raphael, 1993) and daughters of alcoholic parents (Donald et al, 1993). Alcoholism in the elderly is also underreported in the literature, possibly because alcohol problems can mimic the effects of ageing (Gupta, 1993).

In addition, Epstein, Kahler, Mc Crady, Lewis & Lewis (1995) examined common patterns of drinking habits in women. They identified four subgroups of alcoholic women based on individual styles or patterns of drinking habits. They highlighted differences in drinking patterns such as binge, episodic, sporadic and steady drinking. They report that these drinking patterns are common to most alcoholics of either sex. Arguably, these subgroup patterns also deserve investigation. This is especially important in the light of the insights this research may yield for future treatment of alcoholics. Studies into breaking these patterns of drinking may help to combat current high relapse rates in alcohol abuse.

In summary, there is a call for more research into these subgroups of individuals who are alcoholics and their drinking patterns. There is a need to identify what makes an individual more likely to drink to excess than others of a similar background and experience.
Conclusion

It is argued here that traditional models of treating alcoholism such as the medical model, treat alcoholism in a standardised way. Therefore, treating women alcoholics from this perspective, as a homogenous group, is limiting the full potential for treatment and research. Individual differences exist that can range across the full spectrum of psychosocial problems and may influence the patterns of women drinking habits. The psychological model takes account of the psychosocial factors surrounding alcoholism and could therefore provide a more effective model of treatment. Indeed, there is the notion that psychosocial factors also have a role in maintaining alcoholism that may offer valuable insights into reasons for relapse. This has implications for psychological treatment models being developed that address the underlying issues of women’s experiences.

Furthermore, it is argued here that current aetiological theories, research methods and treatment of women alcoholics rest upon male orientated interpretations of alcohol related problems. Moreover, that alcoholism in women has a complex aetiology that may encompass genetic, biological, neurological, social and psychological factors that can predispose some women to becoming alcoholic. These factors may differ in the aetiology of similar alcohol problems in men. Furthermore, research is needed to uncover the reasons why some women become alcoholic and other women with similar predisposing factors do not. Arguably, the only way forward is to investigate subgroups of alcoholic women and their drinking patterns.

In conclusion, the study of subgroups of alcoholics and their drinking patterns can lead to a deeper and richer understanding of the factors that predispose and maintain alcoholism. This sea change in the approach to the research, theories, assessment and treatment of women alcoholics is arguably a long overdue innovation that will reap valuable rewards in future years.
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CRITICAL REVIEW THREE:

A Review of Multidisciplinary Teamworking

Over recent years there has been a shift away from hospital based services into community settings. A way of delivering services into the community is via multidisciplinary teams (MDTs), and plans exist to expand this model of service delivery (Kingdon, 1989) to various client populations, e.g. primary care and elderly services. No clear definition of a multidisciplinary team has emerged, as yet, from the literature. This has primarily been because of the diversity of team styles and the individual nature of teams. Kane (1975) identified the common elements that emerged from most definitions as, having shared aims, distinct roles and a situation that facilitates joint working and communication. More recently, Ovretveit (1993) generally defined a multidisciplinary team as:

"a group of practitioners with different professional training (multidisciplinary), employed by more than one agency (multi-agency), who meet regularly to co-ordinate their work, providing services to one or more clients in a defined area."
This review highlights some advantages and disadvantages of multidisciplinary teamworking in a discussion of the various styles of team organisation. Most would agree that there is little understanding of team processes, organisation and setting up of teams (Strasser, Falconer & Martino-Saltzman, 1994). Therefore, this review will often focus on individual and professional perspectives because of the lack of empirically sound evidence that surrounds the workings of MDTs in the National Health Service (NHS). In concluding, the need for research into MDTs working in NHS community settings is highlighted. Finally, it is argued that style of team is important in MDT working and in the absence of an effective leader MDTs can become unworkable. It is proposed that upon the evidence reviewed here Co-ordinated teams offer the best organisational team style for working in NHS community settings.

Advantages of Multi-disciplinary Team Working

McGrath (1991) summarised the advantages of working more formally within a multidisciplinary team. She argued, as did Ovretveit (1990) and Collinghan, MacDonald, Herzberg, Philpot & Lindsey (1993) that MDTs provide a better service because professionals collaborate together in a more holistic approach to care. These authors argued that MDTs can identify gaps in service provision and enhance knowledge of the way in which others work. Arguably, this creates a potentially more stimulating working environment. They suggested that specialists in MDTs are able to concentrate on their particular skills, whilst contributing to the work of others through skill sharing, thereby improving levels of professionalism.
McGrath also advocated that unqualified staff can reach maximum potential within a team framework because of the better supervision and support available. In an earlier article, examples are given of unqualified staff increasing their skills base in "Patch" teams (teams delivering services to different localities) that had a MDT focus (Hadly & McGrath, 1984).

Ovretveit (1990) suggested that workload management is easier in MDTs as common objectives are established through delegation of tasks, which avoids replication. McGrath (1991) and Collinghan et al (1993) argued that service planning, goal orientation and systems problems can be best addressed in a team. Collinghan et al (1993) also highlighted the value of a MDT in compensating for the limitations of some General Practitioners (G.P.s), and the value of joint or team assessments, which are likely to give a more accurate account of patients' needs.

From the staff perspective, MDTs can provide a supportive and intellectually stimulating workplace, with greater emotional support available for stressful client work (Ovretveit, 1990). Portnow, Kline, Daly, Peltier, Chin & Miller (1991), took a more practical stance, seeing one of the advantages of MDT working as the exchange of relevant information between professionals. Watson (1990) previously had highlighted this aspect in the regular Team Allocation Meetings that are central to MDTs. The purpose of Team Allocation Meetings is to allocate patients to appropriate professionals and communicate relevant information. Watson characterised the main benefits of MDT allocation meetings as information sharing, professional
communication, learning from colleagues, with the opportunity to model good team behaviour and remedy unhelpful behaviour.

However, MDTs also have many drawbacks, which can be best highlighted by discussion of the various formal arrangements that exist.

Types of Team

Ovretveit (1986), in his working paper, described types of formal team organisation in detail and summarised these in his article of 1990.

(a) The Fully-Managed Team

This kind of team has a Team Leader to whom the other team members are accountable, e.g. a Consultant. In turn, the Team Leader is accountable to Senior Managers for the service provided by the MDT. The Team Leader's role is all important. Decisions regarding allocation of referrals, task allocation, appointment of staff, discipline, work appraisal, team policies and proposals may be within their remit. Typically, a Team Leader would hope to achieve a team consensus of opinion, but could overrule team members.

Yank, Barber, Hargrove & Whitt (1992), advocated that Team Leaders must clearly demonstrate their team membership overtly, e.g. by participating in the team's functions, which creates a sense of goodwill. Furthermore, because the role of Team Leader and their leadership style requires respect from other members their personality is important. If, therefore, the Team Leader is perceived as weak or ineffectual, fully-managed teams do not function effectively.
In some settings, such as hospitals, fully-managed teamwork is desirable, because members are uni-disciplinary e.g. nursing. However, Robertson (1990) highlighted the problems that the medical profession have with integrating into MDTs because they have traditionally taken the position of Team Leader. This is less desirable in MDTs with representatives from different professional disciplines because decisions need to be made “on balance” taking team members views into consideration. He also pointed out the lack of training given to physicians, G.P.s and Consultants in MDT work that requires a greater level of collaboration, equally, it may be said that these professionals are conditioned from their training into assuming a leadership role in such situations.

Ovretveit (1985) indicated problems that can arise when team members are close in status, e.g. Physiotherapist, Speech Therapist, Clinical Psychologist. This becomes problematic if the professional expectations and limitations of each team member are not fully understood by the Team Leader. For example, the majority of professionals, such as Clinical Psychologists or Speech Therapists working in MDTs, would not accept a Medical Team Leader's authority over their clinical work (Ovretveit, 1984).

Ovretveit (1993) also stressed the importance of a Leader's ability to understand and use the professional skills of each team member effectively, whilst being sensitive to and valuing professional differences. Fully-managed teams can also have professional boundary problems with respect to patient confidentiality, clinical autonomy, ethical obligations, codes of practice
and conduct (Ovretveit, 1985). These problems are often apparent in badly managed teams and are issues that are in need of clarification even in well run teams.

In summary, traditional fully-managed teams have been effective in uni-disciplinary hospital settings, however, fully-managed teams seem to hold limitations for care in the community because of the MDT focus required. This primarily is because of the professional autonomy anticipated by members of MDTs, which is in direct opposition to the ethos of a fully-managed team.

(b) The Co-ordinated Team

This style of team is the most commonly used in NHS community settings. A Team Co-ordinator is accountable for the performance of the MDT. The co-ordinating role is to organise team members, frequently from other professional backgrounds whilst having individual line managers or professional superiors outside the MDT framework, unlike a fully-managed team.

The Co-ordinator role in this kind of team is curtailed by non-involvement in profession-specific discussions, therefore, they are not responsible for any individual's casework. The duties of Co-ordinator entail ensuring that others carry out team policies, quality standards, procedures and objectives that are formulated by the team members themselves. The Co-ordinator is often a professional working within the team having extra managerial functions and responsibilities. This subtle role shift from leading to co-ordinating, is the main difference between co-ordinated and fully-managed teams.
0vretveit (1986) argued that this style of team can have problems when team members hold similar levels of status, experience and power. For example, team members may experience feelings of being dis-empowered by team decisions that are not in keeping with their own professional standards or expectations. The Harding Committee (1981) which was commissioned by the Department of Health and Social Security, laid down pre-requisites for good integration of Co-ordinated Teams. They advocated that having common objectives, understanding professionals' various roles, function and skills, as well as a flexible approach, are important qualities needed for good MDT work.

It should not be assumed that having a Co-ordinator will automatically lead to a well-functioning team. Role blurring is a common phenomenon that occurs, which leads to team members feeling deskilled. Strasser et al (1994) provided empirical evidence that role blurring by transgressing professional boundaries caused team discord. They reported that inter-professional relations become discordant because of differing perceptions of team processes.

Sims (1986) drew attention to six difficulties that can arise in MDTs and are often demonstrated in Co-ordinated teams:

1. Having multiple employers: several members may have different employers that makes the organisation of the team difficult for a Co-ordinator.
2. Having multiple interests: the competing interests of individual team members may not be compatible with others.

3. Having multiple constituencies: in MDTs, members often have no idea about what other team members are doing.

4. Having multiple rules for procedures: team procedures may be in conflict with individual professional policies.

5. Having multiple expectations of a Co-ordinator: the Co-ordinator can become the scapegoat for feelings of frustration.

6. Having multiple power levels: different levels of seniority of members means some members independently make decisions whilst others cannot.

These difficulties can provide a barrier to MDT working and are problems that most teams must overcome to achieve effective working practises. Returning to the last point, Sims noted how some medical practitioners working in MDTs find themselves in less dominant positions than they would traditionally expect. Sims commented how, when such members are curtailed in this way, they are not motivated to participate in the MDT. This has negative consequences for the team, leading to conflict, the fragmentation of teamworking and the under-mining of the Co-ordinator's role.

Onyett & Malone (1990) examined the qualities needed to be a good Co-ordinator; the best single qualification is likely to be the credibility of the person in the eyes of other team members. This is made easier if there is a clear specification of the role of the Co-ordinator and
mechanisms for conflict resolution are in place before the team becomes operational. McGrath (1991) commented that un-coordinated MDTs created professional conflict or, at the other extreme, "group-think" when members act and think alike, a phenomena first described by Janis (1971).

In summary, all MDTs can experience difficulties in accommodating the similarities and differences between team members. The Co-ordinator role is an important one in bringing together the attributes of the individual professions represented in the team whilst being aware and alert to the professional boundaries that exist between them. A Co-ordinated team has advantages over a fully managed style in that co-ordination allows for more flexibility, less structure and a more collaborative approach to MDT work in NHS community settings.

(c) The Core and Extended Team

This type of team has a central core of group members, with other associated or extended members who are less involved in the team. This may be because they make only a part-time contribution to the team work. Ovretveit (1986, 1990) identified a number of ways in which this type of team can be organised:

1. Core team members are full-time with part-time extended members, with more specialised skills.
2. Core team members are managed by a Leader or Co-ordinator, who also manages extended team members.
3. The Team Manager or Co-ordinator manages core members and monitors the work of contracted extended members.

4. A complicated mix of managed as well as co-ordinated core members, alongside contracted extended members.

There is a strong need for definition of the terms of reference used in teams of this nature. As Ovretveit (1993) suggested terms of reference can have different meanings. For example, "Core" can mean: being a full-time member; governed by team policy; managed by a Team Leader or having formal voting rights in the team. "Associate" can mean: being a part-time member; not governed by team policy; having an outside manager, or having no voting rights. Robertson (1990) argued that teams do not exist in a vacuum and cannot exist without sustained effort. He called for clear, definitive roles of "core" and "associate" members to be identified prior to setting up a Core and Associate Team. In addition, because they are not central to the functioning of this kind of team "associate" members may not have a very high investment in the team.

The Audit Commission (1992) reported that suspicion over the motives of others, diverse objectives, the blurring of professional boundaries and perceived inequalities lead to members narrowly defining their own roles, preventing effective teamwork. These problems could become apparent in Core and Associate teams if terms of reference and individual roles are not clearly defined.
Searle (1991) supported the case for workable role definitions to improve team functioning. A lack of role definition can be particularly problematic with newly qualified or inexperienced members. They may be uncertain of their own or others professional roles and may be lacking in professional supervision (Anciano & Kirkpatrick, 1990). These authors, along with Reiman (1989), had previously suggested that a consultative role to an MDT is preferable for some disciplines. This is because of difficult professional issues such as keeping patient confidentiality in a team setting, can impinge upon professional codes of conduct.

Contrary to the view expressed by McGrath that skills sharing enhanced professionalism in teams such as this, Reiman noted that role blurring can be caused by skills sharing. Team members can lay claim to specialist skills traditionally belonging to another profession. For example, team members claiming therapy skills which are the key skills of Clinical Psychologists. This leads to an erosion of professionalism and skills dilution, resulting in generic ways of working (Reiman, 1989). She also argued that professionals who take on keyworker responsibilities, find their professional skills being eroded and underused in the keyworker role, with resultant feelings of being deskillled.

In summary, Core and Associate teams need careful consideration regarding the terms of reference they use. Furthermore, the effectiveness of the Core and Associate team can become diluted because part-time members may not be fully committed to the team because of other responsibilities. On the other hand, this style of team would appear to have the flexibility to adapt to particular service needs and can accommodate a Co-ordinator or Team Leader.
(d) The Joint Accountability Team

This style of teamwork has no Team Leader or Co-ordinator. The team members decide who will represent their views to higher management. This role of "Team Representative" is often task specific, with responsibilities agreed between team members. Based on egalitarian principles, Joint-Accountability Teams require tolerance and team investment to preserve their ethos. This is especially important in traditional healthcare settings where often others, e.g. G.P.s, assume that Consultants will be taking the clinical lead of the team.

This very fluid style of team can be a shock to members who have previously assumed an autocratic, traditional position in fully managed teams (Onyett & Malone, 1990). The lack of leadership may also present difficulties if a leadership role is adopted by any one member as this is against the principles on which Joint Accountability teams are based. Ovretveit (1986) argued that Joint Accountability Teams, fail to address important issues and avoid difficult problems because they have no Team Leader or Co-ordinator.

The notion of joint accountability cannot easily accommodate the differences between professionals and other members such as Generic Support Workers who may have no professional training. Accountability can be low, especially where there are overlapping areas of expertise, when this occurs members tend to take on work for which they are not qualified (Reiman, 1989). The need for training in developing policies and goal setting in this kind of team was commented on by Dickenson (1989).
Thyen, Theis & Tebbitt (1993), highlighted the importance of all members being equal team players. However, equality in teams may be difficult to achieve due to differences in experience, personalities and perceived power. Because of these problems it would appear that this kind of team is in need of clear goals and objectives to facilitate collaborative working. Although some objectives have already been introduced: Patient Focused Care (Fuchter & Garside, 1992; Black & Garside, 1993); Collaborative Care Planning (Lancaster, 1993); Integrated Care Pathways (Campedelli, 1994). These objectives have been mainly used with teams having a medical bias in hospital settings, e.g. orthopaedics and nursing.

It is not yet clear what effect the introduction of such objectives will achieve and their suitability for MDT working in NHS community settings is still questionable. Porter-O'Grady (1993) discussed the perils and possibilities with patient focused care and the realities for Joint Accountability Teams using these objectives. For example, professionals do not necessarily formulate into integrated, collaborative partnerships; problems exist with roles, power, hierarchies, barriers, suspicions and unresolved feelings that emerge, limiting the team's progress to achieve objectives.

In summary, Joint Accountability teams are by their very nature unstructured. This can cause difficulties because there is no one person ultimately responsible for the organisation of the team. This style of team also leaves it open for any individual team member to assume leadership. This may lead to conflicts with others as they resist subtle or enforced leadership.
However, the attractive qualities of this style of team come in the opportunity for the team members to shape and develop into a team of truly equal members.

Conclusion

It is argued here that MDT work is far from being a refined "state of the art" way of service organisation. MDTs have the advantage of creating a more pervading professional ethos in community settings. However, until there are outcome studies of different styles of MDTs in the community, it will be difficult to evaluate their effectiveness.

In conclusion, there are arguments for the use of all the styles of team outlined here, however, there is a need to consider the advantages and disadvantages of each style of team. Fully managed teams have the advantage of a clearly defined leader, but, can be too rigid to be effective in the community. Co-ordinated teams offer a greater opportunity for collaborative working and are more flexible in nature. From the evidence thusfar, Co-ordinated teams seem to offer the best option for team working in NHS community settings.

Core and Associate teams may be best suited to some NHS community settings as they can be flexible too. But, they have the drawback that Associate members may not be as committed to the team because they are not central players. The most difficulty however, is with Joint Accountability teams where there are difficulties with accountability that can lead to poor professional standards and practise. Particular difficulties surrounding differences in power,
experience and professionalism lie with Joint Accountability Teams and it is argued here that in the absence of any form of leadership, such teams can become un-workable.

Finally, Co-ordinated MDTs may prove to be the best option, at this time, for collaborative working in NHS community settings. Clearly, the need to get the style of team correct is of critical importance, as there is more to MDT work than simply bringing together a group of professionals and calling them a team.
REFERENCES


SECTION THREE: CLINICAL AUDIT
THE ESTABLISHMENT OF A NEW REABLEMENT SERVICE

NOTE

The NHS Trust referred to in this document will be known as the ‘Healthcare Trust’ and any identifying details such as geographic areas have been changed.

INTRODUCTION

The impetus for this report came from taking up a post as a Clinical Psychologist with a new and innovative service. My experience of joining this service and the team in which I worked is described in this document. I have learnt much both from the experience itself and from the academic analysis of the problems. In terms of my own professional development this has provided me with a sharp learning curve that has increased my awareness of difficulties that can arise in teams and in the setting up of new services. This was chosen for inclusion in the portfolio because I needed to make sense of what had happened for my own professional development and because this may be of some professional interest to others.

The post to which I was appointed required me to help set up a new and innovative service named Reablement. This service was to focus on offering support to the elderly frail and younger physically disabled adult population of a rural area. The service was to be delivered by various professionals working in a MDT. A major attraction of this post was the joint-accountability nature of the team (Overeit, 1986) having a strong therapeutic rather than medical influence. In the initial stages my role would focus on planning, resourcing, setting up and organising how psychological services could be effectively
implemented within the team setting. The focus would then switch to delivery of the service and resolving any problems that arose. An important part of the post was to advise from this experience, on the setting up of a similar service in an adjoining locality.

The following is a report of the problems encountered by myself and the other team members and the attempts made in the hope of resolving some of the problems. With hindsight, some recommendations that could have been implemented have been made. However, this report has been written, in the main, as an attempt to understand and learn from what went wrong.

The reality of setting up and operationalising in a new MDT service within a new concept of care is a difficult task for any team. The fact that this particular team had many problems in this task warranted the use of an external facilitator. However, for practical reasons this was not possible, not only was no further funding available but no suitable facilitator could be found. The team found that there was no other way of resolving the problems they encountered other than to elect a facilitator from within the team. It was felt by the team that I should take on this role which from the outset was clearly a difficult one. Therefore, I offer no excuses for the way in which I handled the difficulties that arose except to say the best was done under very difficult circumstances.

However, before any in-depth discussion of the problems identified can take place, an attempt will be made to highlight some relevant background information, define Reablement and its aims as well as detail the membership of the Reablement MDT.

The Background to the Reablement Service

The Reablement Service was a “Purchaser Led Initiative” that was given preference over an originally planned Day Hospital Service that would have had an exclusively medical focus. The original plan was for a Day Hospital, staffed by nurses and fully managed by a Consultant Physician and a Clinical Assistant. However, additional financial support was made available by the purchasers from Government funds. This was to upgrade the original
plans for a Day Hospital for the elderly, to a more comprehensive Reablement MDT Service able to include younger patients. The service covered a wide, rural geographic area that included five towns and a large number of outlying villages and hamlets. The estimated total population of the area Reablement would initially serve was approximately 14,000. With approximately 23% being aged over 65 years and 15% estimated as having a long term illness (OPCS, Ward and Council Parish Monitor, 1991). This was comparable, with national estimates, revealing that 14% of adults in private households had one or more disabilities. Of these 70% were aged over 60 years and 50% aged over 70 years (Coni, Davison & Webster, 1992).

The Definition and Aim of Reablement

With no known published literature, the term Reablement is open to interpretation. However, there appears to be some consensus of opinion that Reablement can be broadly defined as an approach to health care that provides patient access to multi-disciplinary assessment, treatment and therapy. In the main this serves older adults (over 65 years) with a physical disability but does not exclude others who can benefit from this approach.

The aim of a Reablement was to help prevent hospital admission by improving upon assessment and treatment in the community with quick response to referrals and short term focused intervention. It was intended to be a flexible clinical approach, applicable in any setting, that was appropriate to meet the needs of the presenting patient. Patients were therefore seen at the location of their choice, most frequently their own home. It was a move away from more traditional methods of service delivery that are centrally focused on a hospital or clinic setting. The emphasis was on integration of health services across a variety of settings. For example, community hospitals, day centres, nursing homes and residential care homes. It was seen as a move towards implementing the recommendations of the government White Paper, Caring for People (1989b).
Reablement had a health rather than social orientation, with a strong emphasis on outreach work in the community across a wide age range (18 years onward). The focus was on a therapist led service with medical support as needed, unlike services in the past such as Day Hospitals that have been medically led. It involved offering physical and psychological therapy with some medical support, in the community. It was generally considered that Reablement could be distinguished from traditional Day Hospital Services by virtue of its short term focus, together with the inclusion of younger patients. This proved especially attractive in sparsely populated areas where there is a dearth of patients falling into a specific category. In addition, the service could extend its role in an advisory capacity to other services such as Learning Difficulties, where a physical problem could be defined as being either a primary or secondary concern.

The Reablement Team

The Reablement MDT consisted of a number of full time members: an Occupational Therapist, Physiotherapist and Nurse Practitioner. Clerical and administrative duties were performed by a full-time Clerk. There were two half time posts: a Speech and Language Therapist and a Clinical Psychologist. Both of these posts were to be developed into full-time posts with the expansion of the service into the adjoining geographic area. Three Generic Support Workers were provided on a part-time basis with medical support available one day per week from a Consultant Physician and a Clinician Assistant for the Elderly.

Referrals to the team were from any G.P. working in the area. Referrals could be made to the team generally or to individuals working in the team if the problem was more specific e.g. for Speech Therapy only. This was to enable the service to maximise upon the professional expertise offered by individual team members as well as by MDT working.
Bringing together these various professionals as equal players a joint accountability team was a new concept of team working for the Healthcare Trust. No other teams working in the region worked in this very flexible style. All other teams had an identified leader in keeping with the general management style, that being one of top down management (Overeit, 1989) rather than the bottom up style generated by self governing or joint accountability teams. This most frequently was a fully managed model of team.

THE PRESENTING PROBLEMS

Shortly after opening the service some members of the team expressed their dissatisfaction with the way in which their posts had not fulfilled their expectations. The tasks of planning, resourcing and organising the service were fraught with difficulties. As a consequence of these difficulties the delivery of the service became problematic. After consultation with other team members I proposed that those members of the team expressing dissatisfaction should meet together to voice their concerns and identify the problems that were contributing to the situation. At this meeting, which was attended by all the therapists in the team, the central problems were identified. Fundamentally, the service had been badly planned and was functioning in all but name as a fully-managed team. As a joint accountability team had originally been envisaged and advertised this was against the principles on which the team had been recruited, and in turn led to the team not functioning well. These members of the team felt eager to maintain their posts and wished to attempt to resolve the problems. After some discussion, the consensus of opinion was that the only way forward would be to address the issues together. This could be achieved through integrating the team via team building aimed at re-aligning the service with the original plan of joint accountability.

The presenting problems reported here highlight the difficulties experienced in the team. It must be borne in mind that these views may well not reflect the viewpoint of all members
of the team and are based upon my own experiences. The problems identified are as follows:

- **The Primary Problems**

  - Firstly, there appeared to be no clear strategic business plan for the service. It became clear from discussions at Team Allocation meetings that there was no specific plan or remit for the service. For example, there were differing opinions about what the service aimed to provide, the task set and team members were unsure about the patient inclusion criteria. As there was no Project Manager responsible for the team or management structure by which these issues could be clarified the team were unsure of their task.

  - Secondly, the medical team members had adopted the leadership role for the team. Team members were angry and upset that one member had adopted this role by making and implementing decisions without consultation with the rest of the team. Possible referrers to the team had each received a letter indicating that all team referrals should be addressed to the Consultant Physician or to the Clinical Assistant personally. In addition, Team Allocation meetings became fraught when work was allocated without discussion to team members by these members of the team.

- **The Secondary Problems**

  - Some of the team members had previously been managed by the Clinical Assistant. These members accepted being similarly managed in the new setting, however, this authority was not accepted by others in the team.

  - There was confusion regarding the style of the team. Members had been recruited to a joint accountability team, however, the team became one that was fully managed,
furthermore, as some individuals were not full time members the team fell more naturally into a style of a core and associate team.

- **The Contributory Problems**

- There were problems with confidentiality of patients. For example, typing confidential reports was problematic because the administration area was centrally positioned in the Day Room used by the patients, also, staff could be overheard discussing patients whilst on the telephone.

- There were administration and communication difficulties. No system for internal communication had been set up, there had been no plans implemented regarding basic administration requirements, e.g. files, filing cabinets, paper, etc.

- There was conflict between the medical and therapeutic team members. This was primarily because the team had quickly taken on a medical focus which was out of step with the concept of joint accountability and the principles on which the therapeutic members had been recruited to the team.

In addition to these problems the service was attempting to serve a diverse population with differing needs. With no help available from any other source, the team members were obliged to resolve the difficulties outlined in this report for themselves. Overall, the problem for the therapists working in the team was to create a working environment that enabled them to perform their duties and reflected the posts to which they had been appointed.

The aim here is to address the main task of gaining insights into what went wrong in order to understand and learn from the experience. The problems that contributed to the team
not functioning as a joint accountability team as had originally been intended are highlighted. To compliment this, the theoretical background to the problems were investigated.

The previously outlined problems are discussed here in some detail:

**The Primary Problems:**

**A Lack of Business Planning**

One of the main problems was that the concept of a Reablement Service had attracted more funds from the purchasers than a Day Hospital, because of the broader service it could provide. These extra funds were used to expand the original plans for a Day Hospital for the Elderly into the wider service that Reablement could offer. However, because Reablement was such a new and all encompassing concept it did not fit naturally into any division of the Healthcare Trust’s management structure. The Trust had a structure that was headed up by a Trust Board consisting of representatives from each division within the Trust organisation. These divisions were formalised by profession, such as the Nursing Division, Professions Allied to Medicine Division, etc. Therefore, because the organisation of the Trust did not allow for a team where members might be from more than one division there was no clear route for management of the team available. Consequently, there was no Project Leader or Divisional Manager who had direct responsibility for the service, therefore, there was no formalised business plan created for the service.

This was further compounded by the fact that it was a service to the elderly, as well as the younger physically disabled, it was also hoped that it could offer some help to patients with a learning disability. Because the remit for the service was wide, encompassing various patient populations, no division within the management structure could offer direct line management. These factors created difficulties for the team who were left to devise their own policies and procedures, however, given that the team was effectively being
medically led this became a difficult area of discussion. For example, a policy was imposed by the medical member that all patients using the service should be medically screened. This raised ethical questions regarding the suitability of this policy for those patients referred to clinical psychology or for speech and language therapy.

All employees in health organisations are governed by the policies formulated by the management structure in which they function. Rakich, Beaufort, Longest & Darr (1992) discussed this in relation to objectives in health care services making a useful distinction between primary and secondary objectives that had an important bearing on Reablement. Primary objectives focus on decision-making processes and thinking within an organisation. This effectively marks out the boundaries within which managers and employees must act. For example: contracts of employment, conditions of service, terms of employment, insurance, salary scales and job descriptions (Rakich et al, 1992). In addition, management policies need to be in place to address such important issues as equal opportunities, grievance procedures and disciplinary measures (Adirondack, 1992, Rakich et al, 1992).

Rakich et al (1992) also discussed the secondary objectives that formulate the organisational structure of management, such as divisional and departmental policies needed to conduct the everyday business of the organisation. Without such organisational objectives individuals are left to formulate their own working practices. This is ineffective management in terms of both time and expenditure.

Clearly, there were problems in formulating a line of management that would clarify the aim, purpose and focus of the service. The importance of business planning and having a line of management that is clear and accessible is highlighted as is the importance of policies and policy making. The difficulties created by a lack of good management made it easy for the other primary problem of the medicalisation of the service to emerge.
The Medical Management of the Service

The Consultant Physician and Clinical Assistant adopted a leading role in the management of the team, as they would have done if the original plans for a Day Hospital had proceeded. As a result the team became fully managed having a strong medical bias with the medical team members attempting to control all decision-making for the team. They accepted all referrals made to the team, promoted themselves as leaders of the team to others and took control of all meetings aimed at patient allocation and the development of policies and procedures.

It was stated in each team members contract with the Healthcare Trust that the team was to be one of joint accountability. The team had been advertised and promoted as a joint accountability team in which decisions and policies are formulated from joint working. The therapists in the team attempted to influence decisions, but these attempts were ignored. This was because decisions made by the medical members were implemented by some members of the team who appeared anxious about challenging the power of the medical way of working.

The advantages of working in a fully managed team are highlighted by Yank et al (1992) and are focused on the leadership role that is important in such teams. Having a leader minimises uncertainty as the leader is ultimately responsible for the functioning of the team. There is a clear structure to the team therefore role differentiation is easier. However, there is an increased risk that team members will not approve or agree with the decisions made by the leader that may influence the professional practice of the team members. On the other hand, joint accountability teams are not subjected to decisions being forced upon them by a leader. However, they may be faced with other difficulties such as reaching consensus about decisions and handling conflicts that arise. In addition, there can be difficulty with unequal power between professionals and generic workers in joint accountability teams.
As Robertson (1990) noted the medical profession often have problems integrating into MDTs, as the way in which they have traditionally operated is by leading the team. Sims (1986) recognised that medical staff working in teams such as this often find themselves in less dominant positions than they are expected traditionally to occupy. The autocratic position that many traditionally expect in teams is frequently unavailable to them in MDTs (Onyett & Malone, 1990).

This serves to highlight the problems experienced by teams and other such groups that have no elected leader or representative. Research is very limited into this aspect of team work. Overeit (1990), gave no indication of the problems that could be encountered in joint accountability teams.

Therefore, it must be said that the primary problems outlined above may have been prevented with good management. However, under the circumstances the primary problems married well together to contribute significantly to the development of the secondary problems discussed here:

The Secondary Problems:

The Appointment of Staff to the Team

Although the therapists in the team had been selected and interviewed from within their own specialism, some of the other team members and generic support staff had transferred from the local Day Hospital. Here the medical model of working had been operational under the directive of the Consultant Physician and Clinical Assistant for some years. These re-deployed members lacked MDT experience and skills for working in the community setting of Reablement. This lead to difficulties with maintaining professional standards and collaboration with the medical model of working being promoted. In
addition, there was no clear and concise job description or personal specification for the posts they held. This was buttressed by the fact that this was a rural area, the Healthcare Trust being the largest employer in the region. The nearest Trust where alternative work could be available was 70 miles away. This factor was very influential upon team members, the fear of losing their posts was great, as the area was one of high unemployment.

Of significant note to the team members who had previous experience of MDT working, was the job title Co-ordinator. Overeit, (1989) used this title in conjunction with the role of co-ordination of team working, however, in the Reablement setting this title had been given to the Clerk. This proved to be misleading to those who had previously worked in MDTs. The assumption being made by the therapist team members, subsequent to taking up their posts, that the Co-ordinator was responsible for the co-ordination of the team, similar to that of a Project Manager.

Effective teamworking can only be achieved by careful selection of team members and support for team development. Adirondack, (1992) advocated the use of a Personal Specification for staff selection that laid out the criteria for individual posts. Personal Specification ensures that postholders are selected on the basis of suitability, merit and ability rather than on subjective judgement. Adirondack (1992) divided the essential requirements of a Person Specification into categories of: experience, skills, knowledge and ability, qualifications, personal attributes and personal circumstances. In addition to the essential requirements are the desired qualities of candidates. These are less circumscribed and more difficult to address but generally consist of relevant experience or additional qualifications.

The need for a Job Description is also stressed by Adirondack (1992). A comprehensive Job Description should give the candidates a concise and clear indication of the kind of work they would be undertaking. This is based on a detailed analysis of the tasks to be performed and the qualifications necessary. It should include: a job title, detail the main purpose of the post, state to whom the postholder is accountable, specify any supervisory
responsibility and give details of the main responsibilities of the postholder. This should also summarise the main conditions of the post, including, salary, hours of work, pension rights, holidays, etc. (Adirondack, 1992). It is not advocated that these aspects of a job description are too flexible (Adirondack, 1992), although some, such as salary are frequently negotiable.

It may be said that the difficulties experienced were in part due to a lack of personal specification of the posts and a lack of clarity concerning job descriptions. This led to the appointment of some unsuitable staff who lacked the skills and experience to conduct their duties in a joint accountability team setting.

The Multidisciplinary Team Style

One of the major problems was the recruitment of staff to a joint accountability team that transpired to be a mixture of team styles or models of working. Although advertised as a joint accountability team, in reality, because of the full and part-time nature of the team members involved, it could be said to have been a core and associate model. On the other hand, as the medical team members dominated the decision-making process it could also be described as a fully managed model of teamworking.

The team had originally been conceived by the purchasers as joint-accountability in style with no direct line management for the team. Therefore, no mechanism existed promoting the equality of team members based on the egalitarian principles of joint-accountability (Overeit, 1986). In addition, there was no way that equality of membership could be enforced, or medium through which team conflicts caused by the lack of equality could be mediated or resolved. The nationally recruited team members who were all therapists were confused and disappointed that the joint-accountability team to which they had been appointed did not materialise.

It had been envisaged by the purchasers that a joint accountability MDT would encourage equality within the team membership. This style of team organisation has no Team Leader,
Co-ordinator or Team Representative and has been discussed in detail by Overeit, (1986) in his working paper. Ovretveit, also highlighted other styles of teams. He pays particular attention to team leadership and co-ordination in his working paper on the organisation of MDTs. He suggested that these are important issues that need clarification prior to a service becoming operational. In addition, he proposed that the style of team chosen should be based upon the task set for the service.

Clearly, the confusion regarding the team style of working was unavoidable given that there were some members of the team who contributed only part of their time to the team. This was compounded by the medicalisation of the service and a medical figure seen as the leader of the team by some team members and outside agencies such as the GP’s and not by others.

The Contributory Factors:

Problems with Confidentiality

Major concerns had been raised by some team members concerning various aspects of maintaining patient confidentiality within the Reablement Service.

1. The work area for the administrative staff was centrally positioned in the Day Room of the Unit. It soon became apparent that confidential material could be seen and heard from this work point by patients, visitors and other staff alike. This was particularly problematic in relation to telephone calls being overheard by anyone present and the computer visual display screen being visible to patients.

2. The Day Room was used to take routine case histories and for simple medical procedures, such as the taking of blood samples. Patients undergoing these procedures could be observed and overheard by other patients present in the Day Room. This was not felt to be appropriate by the non-medical staff who all lodged complaints with the medical team members.
3. The use of multidisciplinary team notes created the most distressing problems for staff. The team notes could be accessed by all team members, including the administrative staff. On many occasions, the notes could not be located when needed, this created much frustration for the team members. Of great concern to the therapist team members was the potential for the notes to be lost or misplaced. Thus, team members felt they could not contribute details of their work to the shared MDT notes.

Under the directives laid out in The Patients Charter, (1992) which sets out the Government’s programme to improve and modernise the delivery of service to the public, every person is entitled to privacy and confidentiality. These are rights and standards that highlight the commitment of the NHS in maintaining dignity and privacy for patients. Clearly, the value of multidisciplinary working in the community has yet to be demonstrated as the NHS shifts focus putting patient's first (Caring for people, 1989b). Indeed, the legal implications of multidisciplinary working have yet to be put to the test. It begs the question of who is ultimately responsible and answerable for the maintenance of confidentiality in team situations.

Clearly, there were problems with the maintenance of confidentiality in the Reablement setting. This draws attention to the fact that planning is important at every level when devising a new service. The problems experienced here led to patients having access to information regarding the treatment of others and contributed to the low professional standards of some team members.

Administration and Communication Problems

The administrative aspects of the Reablement Service had not been put into place subsequent to the team becoming operational. The viewpoint at that time was that as staff came on board they would devise their own systems for communication, etc. with individual team members being responsible for any specific administration tasks that related to their own profession. In addition, the administrative staff placed a greater
emphasis on medical work than on work conducted by other team members, e.g. typing, ordering of equipment, etc. The reality became one of confusion and frustration as team members struggled to adapt to a new environment with little practical structure available to help them organise themselves.

In practice, this meant that staff needed to organise basic equipment relating to their profession, for example, tests, patient files, filing cabinets, desks. Furthermore, insufficient computing facilities and telephones created communication difficulties. A system for monitoring the performance of the service had not been devised and it had not been specified how relevant data would be collected. At the same time team members were required to run a service to patients that left limited time for these systems to be implemented.

As Adirondack (1992) rationalised, effective management/leadership in organisations can be achieved through the practical organisation of the service. Particularly relevant is the management of administration, paperwork and internal and external communications. Time management, performance monitoring and the management of meetings need careful consideration. It is important that systems and methods of working are clearly stipulated with guidelines from the management hierarchy in place from the outset.

As effective organisation of the service had not been achieved prior to the service becoming operational this created further unnecessary difficulties that could have been avoided. The frustration created when the practical, organisational duties could not be carried out effectively did much to harm working relationships between the administrative staff and the therapeutic members of the team. In addition, there was an emphasis on the importance of the medical work conducted and this work was given a priority status by the administrative staff.
Resultant Team Conflict

Seeking help for any of the difficulties outside the team proved to be problematic. Although each team member had a manager for their professional work, these managers had no responsibility for the team itself. Therefore, they had no power to prevent the team from being taken over by any powerful member. This also meant that there was no vehicle by which change could be mediated, complaints heard or conflicts resolved. Therefore, the team had to attempt to resolve the team conflict from within the team itself. However, any attempt to address the conflict and achieve resolution of the problems resulted in further distress as the medical members refused to acknowledge the equal status of the other team members within the joint accountability concept of team working.

In practice, this meant that the therapists in the team felt powerless to prevent the medicalisation of the service. They also felt unsupported by their own professional managers who were unable to bring about change because of the lack of formal authority they had with respect to the other team members.

Adirondack (1992) highlighted the desired outcome to conflict resolution and recommended starting with an agreement on how conflicts should be resolved. Steps in conflict resolution are laid out in a simple format by Adirondack (1992). In brief, the requirements are as follows:

1) Each party should have opportunity to define and clarify the issues as they view them.

2) Opportunity for the parties to request why they want a situation to change.

3) Identification is needed regarding common goals and interests.

4) Definition of the areas on which agreement is essential should be identified.

5) Clarification of the facts is needed.

6) Discussion of suggestions for resolution needs to take place.
7) Agreeing a solution and how that is to be implemented.

8) Ensuring that the parties are willing to implement the solution.

9) Reviewing the situation at a later date.

A specific action or series of actions should be implemented to end the conflict and a solution sought. Reconciliation between conflicting parties being the responsibility of those involved in the conflict. In serious disputes an intermediary may be the only way forward (Tjosvold, 1989). As this author noted, if the underlying reasons for conflict are not revealed the conflicts will continue. An intermediary may be necessary particularly with groups, in order that negotiation and arbitration can take place.

The therapists felt vulnerable to the fact that should the service become formally accepted as medically led then their posts would be in jeopardy because they had spoken out against the medicalisation and leadership of the team. It was this concern that prevented the therapists from directly confronting the secondary and contributory problems effectively through conflict resolution procedures as suggested by Adirondack (1992).

The issues discussed here created the basis of the problems the team were encountering. The following is an analysis of those problems and how they link together. An attempt is also made to diagnose the problems using an organisational systems approach.

**FORMULATION AND DIAGNOSIS**

**Problem Formulation**

It appears that in the first few weeks of opening the medical practitioners skewed the service towards the original plans for a Day Hospital that pulled the team towards a medically led service. This was achieved by overriding the decision making process and
enforcing their own ideas, based upon their previous experiences of controlling and managing a team in keeping with a traditional fully managed style (Ovretveit, 1986).

The joint accountability approach of teamworking had left team members open to control by others. The therapists in the team identified the value of having a Project Manager, Team Co-ordinator or Facilitator who would have the formal authority to address the conflict regarding the medicalisation of the service. However, because of the joint accountability principles on which the team was based this was not forthcoming. In this respect the principles of joint accountability worked against the team. Therefore, no-one could challenge or prevent the medical members from taking over the role of leader. This was in direct opposition to what had been planned and not in keeping with what had been offered to the therapists in the team at interview.

Although, management policies existed regarding terms and conditions of employment (the primary objectives), Reablement had no divisional structure from which to operate (the secondary objectives). It was this that created the line management difficulties. Furthermore, no time had been given to the development of organisational and service policy formation. Arguably, it was at the secondary level of management that the Reablement Service was wanting. This situation also highlighted the difficulties that can arise from purchasers being prescriptive about service provision. Indeed, it could be argued that it is, in principle, impossible for any service to serve people suffering from such a range of disabilities and having such diverse needs.

Many of the problems had arisen from having a leaderless team that created a vacuum into which the medical practitioners stepped. This was supported by some team members having been managed by them in the past not being able to make the transition to being an equal in the team. As Ovretveit (1990) has previously pointed out, a team leader will emerge whether the emergent leader has the qualities needed to lead or not. Having no identified leader meant that problems percolated unabated and without a structure by which resolution of the problems could be reached. There was no means of arbitration or
negotiation possible, which lead to hostility, entrenchment of ideas and distressed team members. As Tjosvold (1989) indicated, if the underlying reasons for such conflict are not addressed, then the conflict will continue. There had been no attempt at resolving conflicts within the team because no forum for the debate of such issues existed.

Reablement therefore, became a leaderless spin-off within the organisational structure, that had no clear ownership by any part of that organisation. Thus, when problems materialised there was no acceptance of responsibility at higher managerial levels, i.e. the Healthcare Trust Board. This lead to the team feeling afloat from the management organisation. These mistakes could largely have been overcome if there had been an effective Project Manager with a clear vision of the service.

Contributing to the difficulties were the problems about lack of privacy, confidentiality and the practical organisation of the service. The recommendations laid out in the Patients Charter (1992) stipulating the importance of patient privacy had clearly not been adhered to in the Reablement Service. In addition, the communication and organisational systems created further problems. This could have been overcome to a great extent by the clarification of individual roles and responsibilities, clear organisational procedures and adequate communication systems.

Because the Reablement Team had no specified leader, a wide and unclear remit and had become fully managed this lead to continued unresolved conflicts within the team. The inequalities within the team were keenly felt which led to many heated discussions that could not easily be resolved. As no forum for conflict resolution was available, this led to each member struggling to assert themselves, leaving them feeling open to criticism and vulnerable.

Organisational Diagnosis

Before any action to resolve the problems could take place there was a need to formulate the problems into an organisational diagnosis (Fraust, 1990). Fraust advocated the concept
of 'executive insight' to analyse problems within any organisation that involves people working together. This provided a relevant and useful model for diagnosing the problems of Reablement from an organisational and systems perspective.

The concept of executive insight is based on three key components. Firstly, external factors that can influence an organisation and which cannot be controlled, e.g. the parent organisation. Secondly, and most importantly, the organisational factors that reflect the way the organisation usually acts. These organisational factors are divided into strategic elements, e.g. the purpose and structure of the organisation and the subsystem, e.g. the identification of the client group and administration organisation. Thirdly, the end result which are non-emergency situations that arise from poor organisation and are best dealt with by eliminating their causes, e.g. low morale.

Using the executive insight model (Fraust, 1990) as a diagnostic tool helped to formulate and clarify the issues needing to be addressed in Reablement. Clearly, the team did not have any influence over the parent organisation, the Healthcare Trust. The main problems were diagnosed as being within the organisational factors, which reflected in the end result being one of lack of morale and dissatisfied team members. The difficulties at the organisational level were identified as being primarily within the purpose and structure elements: Reablement had no clear purpose and direction; there was no clear management structure and delegation of tasks and control of the team was poor. In addition, there were problems with the subsystem elements; there was no clear boundary around the target population; no way to transform inputs (professional skills, communication systems, etc.) into outputs (service provision, administration tasks). In addition, insufficient team building had been undertaken, or budgeted for in the formative stages of the team. This had allowed a traditional way of working to evolve in a potentially innovative service.

Having analysed and diagnosed the problems within an organisational systems perspective the identified problems needed to be resolved. Direct confrontation or using the principles of conflict resolution as described by Tjosvold (1989) were considered and rejected on the
basis that this may have been viewed as a direct attack upon the medical model of working and would do little to promote good working relationships. In addition, there was no outside facilitator to lead such a meeting. I therefore considered that using the medium of teambuilding was an approach that was less confrontational.

PLANNED INTERVENTION

Organisational Development and Team Building

Following the examination of the problems using the executive insight model, I made the proposal that conflict resolution could be attempted via a series of meetings and workshops. These were to be aimed at improving the problems within the strategic and subsystem elements of the Reablement Service. Some of these problems could be said to be inherent in any new and innovative service such as Reablement. It would be expected that certain difficulties would manifest due to the broad remit that covered such a diverse population of patients. Defining the remit more closely by means of discussion through teambuilding would be a constructive step in the pursuit of conflict resolution. In order to achieve consensus it would be necessary for the team to function co-operatively, thus enhancing the possibility of resolving some of the issues surrounding the equality of membership.

An Organisational Development (OD) model (Liebowitz & De Meuse, 1981, 1982) was deemed the most suitable approach to the meetings and workshops. This was because OD offered various models of teambuilding that were all relevant to the Reablement Service. It was hoped that this would help accommodate change in the way the team was operating, enable it to reform, strengthen and lead to better working relationships. Thus, to provide a vehicle through which the organisational difficulties could be resolved. The intention was to create team goals and objectives, clarify the roles of team members, resolve some of the difficulties and hopefully lead to an improvement in team relations and cohesiveness. This would then also provide a forum for conflict resolution as outlined by
Tjosvold (1989) whilst channelling human resources into bringing about organisational change.

As Maddux (1990) indicated in his handbook on team building much work needs to be done before teams are operational to create the team ethos, philosophy and ethic. The usefulness of team building has been stressed by Liebowitz & De Meuse (1981, 1982), especially when establishing a new team such as Reablement. The Organisational Development (OD) approach they advocated was also supported in the work of Iles & Auluck (1990). These authors proposed using an outside facilitator in team building, which would have been most appropriate in developing the Reablement Team.

Liebowitz & De Meuse (1981, 1982) defined team building as a long-term, data-based intervention. In their view work groups experientially learn, by examining their structures, purposes, norms, values and interpersonal dynamics to increase their skills in effective teamwork. They argued that team building is very helpful when establishing a new team, offering a vehicle by which the team can accommodate change, reform, strengthen or improve relations between existing teams and services.

Liebowitz and De Meuse (1981, 1982) described various models of team building:

- A Goal setting model - creating goals and objectives for the team as a whole.
- An Interpersonal model - improving group cohesiveness through open communication and support.
- A Role model - clarification of role expectations, thereby reducing conflict and ambiguity.
- A Managerial Grid model - developing a culture for the team that emphasises problem solving.
The threads from each of the models they outline are central to the authors Organisational Development (OD) approach. They recognised the methodological problems of past research into team building, with particular reference to the inappropriate application of research methods in some studies.

Team building has been employed for some years as a way of bringing together all members of a team in a professional and social way. This is to improve upon team organisational effectiveness and communication. However, multidisciplinary teams can be beset with problems, because of differences in professional backgrounds that can detract from the functioning and effectiveness of the team. Iles & Auluck (1990) discussed the effectiveness of teamwork where members are from a variety of backgrounds. They proposed that using external advisors can facilitate good team building, they also advocated an OD approach to improve group interaction. From this perspective, which is concerned with team planning and development, changes can be accommodated. The aim of this approach to team building is to improve group and intergroup processes by using behavioural knowledge within a systems view of organisations. The work of these authors outlines the social and psychological theories of intergroup relations and demonstrates that a task orientated, client centred approach is useful in creating, maintaining and improving multidisciplinary team working.

Clearly, there was need for urgent measures to be taken before team members resigned. The plan I made was to initially focus on defining the remit of the service more closely and clarifying the roles of team members to encourage team working. Focusing on these issues would be of value to all members and provide a fairly neutral subject for discussion. I considered that some of the other issues would be too volatile and lead to heated discussion, thus not facilitating what was being attempted here as an exercise in working together.

The type of intervention chosen rested on the practical nature of the environmental factors. Firstly, there was no other facilitator available that may have had more suitable ideas about
resolution to the difficulties. Secondly, the longer the situation went on un-addressed the more difficult it may become to resolve. Finally, the goal setting model proposed by Liebowitz & De Meuse (1981, 1982) offered the opportunity for the team to work together in a teambuilding exercise. By creating a goal for the team as a whole and clarifying roles it was hoped that a culture for the team could begin to be developed whilst at the same time improve group cohesiveness.

INTERVENTION

The purchasers were made aware of the plans and encouraged myself and the other therapists to organise the workshops and meetings aimed at addressing some of the problems. All the therapists, re-deployed members and the generic workers agreed to attend the meetings. With the purchasers encouragement the medical team members also agreed to attend the meetings and the first one was planned and organised by the therapists in the team. This was as follows:

Team Building Day

Details of the programme for the day can be found in Appendix 1.

To address some of the problems, a representative member from the purchasers (Purchaser Representative) was invited to the first meeting. The meeting took place two months following the Reablement Service becoming operational and was organised by two of the therapists in the team. All team members were invited and all attended. The aim of the meeting was to seek clarification of the team's purpose and role in the community from the purchasers, to seek a clearer remit for the service, role clarification of the members and to facilitate better working relations within the team.

Team Building Day Discussions

Each member of the team gave a 10 minute talk on their role in the team. This primarily focused on a description of their profession and how this was to fit with the requirements
of the service. What each team member had to offer from their profession was discussed and what they saw as their role in the team. It was realised from this that each professional and Generic Support Worker in the team could gain from spending time working alongside each other, much therefore could be learnt and shared. Discussion of how this could be achieved took place with an agreement that this would take place within a time frame of two weeks. Each team member would rotate spending at least the period of one morning with each other professional in the team. This was to include all administration staff and generic support staff.

Clear distinctions could be found between the core skills of each profession represented in the team. A discussion took place of how these core skills could be best utilised in the team setting. Some degree of skills overlap were inevitable, some of the professions represented in the team were complimentary to each other such as occupational therapy and physiotherapy. It was acknowledged that other professions such as medicine and clinical psychology had less in common due to the differing nature of their work. The generic support workers found this particularly useful as they did not fully understand the work of some of the professional members.

The term Reablement had been interpreted differently by each professional working in the team. The Purchaser Representative felt that to some extent Reablement should have a flexible definition in order to encompass all those wishing to use the service. The team raised the point that this could lead to generic working with no specific remit for Reablement. The population of the geographic area was scattered and insufficient numbers of patients met any narrowly set criteria. The discussion focused on which patients could be excluded from Reablement, in order to define the service remit and what the service should be working towards providing. It was agreed that the priority would be on attempting to meet the Reablement needs of the elderly frail and that a limited service could be provided to younger disabled adults.
The Purchaser Representative felt that Reablement should be primarily aimed at the elderly-frail population, with a secondary focus, on the young physically disabled living in the community. The neglect of services to the younger patients was acknowledged, as was the difficulty in mixing younger patients with frail, elderly patients. The Purchaser Representative also indicated that the service could be extended into other under-resourced areas such as Learning Difficulties. This was met with apprehension by the team who unanimously felt that this would create a poor quality service spreading itself too thinly across the various needy populations. This could lead to a generic service having no specific purpose or population to serve.

Overall, the meeting went well with some clearer objectives for the service emerging from the discussions. There was also some evidence that co-operation was evolving between some team members

Action Plan resulting from the Team Building Day

1. That it would be useful to spend time getting to know each other's area of expertise. It was proposed that this could be accomplished by developing a short term project having two strands. Firstly, a day allocated to "trailing" another member of the team from a different professional background. Secondly, in-house training sessions run by each professional team member to develop and improve the work of the Generic Support Workers. The Speech and Language Therapist had a strong interest in coordinating this for the team and took on this responsibility. It was decided that this should be on a monthly basis so as to facilitate the professional development of the generic team members, all of whom were participating in further training.

2. There was a need for further discussions within the team, concerning the development of the service. It was proposed that the team members meet each week initially and then monthly to discuss some of the issues as they arose. Therefore, a Core Planning Meeting was to be held on a regular monthly basis to develop policies relevant to
service needs. Initially, this would provide a forum in which views could be expressed and conflict resolved.

3. The need for further team building events was recognised, especially in the light of the fact that some team members were from outside the locality and other members had no experience of teamworking. It was agreed that team building exercises should be a priority for the team and would be arranged on a monthly basis. A program for the team building meetings would be constructed bearing in mind the organisational development approach to team development. It was felt that this would be best co-ordinated by myself and would ideally require an outside facilitator.

4. A decision was made that future Team Allocation Meetings would be chaired on a rotational basis. Minutes would be taken of the meetings and those more used to chairing meetings would take the lead in this initially. A set of guidelines for the Chairperson would be developed to facilitate and make clear the duties of the Chairperson. The physiotherapist agreed to draw up the guidelines for the Chairperson and a rota for leading the meetings was developed.

5. Further guidance was needed by the Purchasers to the Reablement Team with respect to developing a clear vision and directive on where the service was headed in the future. To facilitate this the Purchaser Representative agreed to meet with the team on a regular basis until the service was established.

It was clear from this meeting that the purchasers had a fairly loose definition of the service and the population they wished Reablement to serve. The purchasers lacked a clear vision of what they were trying to create in Reablement. However, some positive ideas had been generated from the meeting and there appeared to be some consensus of opinion that the objectives would be best met by joint working.
At this point in time I considered carefully the progress made by holding the Team Building Day. Overall, it had been successful, however, whether the team should be fully managed or jointly accountable was still not adequately being addressed. On reflection, some of the ill feeling had been reduced by using the OD approach. It was hoped that this would provide a co-operative basis for the style of team issue to be raised at the next team building meeting.

The Implementation of the Action Plan

One month later there had still been little change in the morale of the team, the conflicts could still be felt by all concerned. The recommendations for action that had been discussed at the Team Building Day had not been fully implemented. This was because despite the therapists' best efforts to implement the action plan agreed on the Team Building Day, their efforts lacked the co-operation of all the team members.

Firstly, the trailing exercise had worked well with most of the team, the team members that took part reported finding the exercise useful and constructive as well as enhancing relationships between the members. The Generic Support staff had taken it in turn to spend time with each therapist and had been encouraged to ask questions and where possible get involved with the work of the individual they were trailing. However, the medical members did not wish to participate due to lack of time available for the exercise.

Secondly, to facilitate in-house training the Speech and Language Therapist organised a session for the team on speech deficits in older adults. This was well received by all that attended and a programme of training sessions was generated for the coming months that included topics such as memory problems, the psychological effects of stroke, caring for patients in their own home, etc. This first session was well attended by all team members apart from the medical members of the team who could not find the time to attend.
Thirdly, the introduction of the Core Planning Meetings took place, and these were well attended by all staff. However, the medical team members quickly took control of these meetings by dominating any discussions on policy formation. The Chairperson was rotated for these meetings, but overall, most of the team were inexperienced at handling meetings of this kind.

Fourthly, the guidelines for chairing meetings were drawn up and circulated and team members took it in turns to chair the Team Allocation meetings. Again, some less experienced members found the role of Chairperson very difficult, especially if they had previously been managed by the medical staff present at the meeting. This led to a lot of anxiety but with the help and support of other team members they coped with this difficult task.

Overall, the lack of co-operation by some members was keenly felt by the other team members. At this point some team members were again questioning their future with the service and morale was again low. At my request one of the Trust Board Executives offered to lead a workshop to address the issues again. The aim of this workshop was to discuss joint accountability and the appropriateness of this approach in meeting the needs of the population it was to serve.

The Reablement Workshop
The agenda for the workshop can be found in Appendix 2.

Overall this workshop highlighted the way in which the service had become much more medically focused than had been envisaged. It was acknowledged that Reablement had originally attracted the various professionals to the service because of the joint accountability style it had proposed and the therapist led service it had promoted. The disparity between what had been expected and the reality of a fully managed medically led team was discussed at some length with no successful resolution.
The medical members of the team felt that every patient referred to the team should be screened medically. It was proposed by that all the team should be involved in medical screening procedures such as blood tests, bed sore assessment and assessment of incontinence. This was in direct opposition to the views expressed by most other members of the team and was difficult to reconcile with the original intention of the service. This proposal also brought into open conflict the medical team members with the therapists who regarded the requests to involve them in medical assessments as unethical. Clearly, this was the central core of the division of interests within the team.

The discussion at this workshop did not move beyond the expression of the therapists discontent about being asked to perform medical procedures. The Trust Board representatives agreed that the screening of all patients by the medical staff could take place and suggested that it would be very useful if all the team would co-operate with the collection of blood and urine samples, etc. The situation became one of stalemate, the therapists arguing strongly that this was an inappropriate use of their time and expertise. Furthermore, that this would be regarded by their individual professional bodies as highly unethical. This effectively ended any discussion about joint accountability team working as clearly the Trust Board were supporting the medical view.

EVALUATION

Professional Development Issues

In summary, the therapists in the team had held out some hope that the situation was one that, with careful handling, could be brought to an amicable conclusion. What had not been anticipated was that the Trust Board would support the medical practitioners. What was clear was that the team would never become one of joint accountability. This raised the question whether the concept of Reablement had been used to procure further funding for the originally planned Day Hospital from the purchasers.
In concluding, it appeared that in directly addressing the issue of the style of team working some answers were given that clarified that the team would be medically focused and fully managed. In this situation it would also have to be concluded that a joint accountability team would not be viable. Indeed, it could be said that the Reablement MDT had never been intended as being any more than a joint accountability team in name only.

This report has highlighted the problems that can manifest in such teams and is in keeping with the previous findings of past literature (Overeit, 1986, 1990) on team working. The primary problem appears to be that without a leader a team can be subjected to a power struggle as each member attempts to assert their viewpoint. Without a definitive decision maker or leader this can become an impossible task. The advantages of working in this kind of team may be the autonomy it can afford professionals in working closely together in a team setting. However, the disadvantages of joint accountability working lie in the question, who is accountable and responsible.

Therefore, it is concluded here, that although this style of team may work well in some settings, careful consideration needs to be given to the suitability of this style in meeting the needs of the service in which it will function. It is proposed here that this may be a more suitable style of team working for a team of therapists or professions from similar backgrounds. From my experience, it does not appear to work as well when there is a diversity of backgrounds of unequal status represented in the team.

**Personal Professional Development**

On reflection, my position of being a team member and facilitator of change in the process of the team building meetings would seem to have been untenable. The problems reported may have been accurately formulated and appropriate action may have been taken to address the issues. However, this position was a difficult one to balance and in ideal circumstances would never have arisen. The position of my having a duality of roles led to difficulties in maintaining objectivity in the role of facilitator of the process whilst also providing a service to the team. This created some bias as it is difficult, some would say
impossible, in this kind of situation to maintain an objective perspective. An impartial facilitator would have been more successful in this role. As Iles and Auluck (1990) reported an outside facilitator can maintain a detached and objective viewpoint.

Shortly after this workshop, after careful consideration and reflection on the past months and the work that had been done to try to resolve the problems, I decided to resign. Following my resignation and my subsequent return to my place of origin I took up a post in Adult Mental Health specialising in women with physical health problems. This was with a NHS Trust that had been my previous employer some years before. The fact that I knew the Trust and the department to which I returned was a very important factor in my decision to take the post. I was anxious to return to 'a place of safety' in order to recuperate from the experience.

Shortly after my return I entered into a therapeutic relationship to help me to come to terms with some of the more personally damaging aspects of the past months. As part of that therapeutic process I decided to write up my experiences for inclusion in this portfolio. It has been difficult to be dispassionate about the experience and this has created problems with objectivity in the writing up of the thesis. However, I have gained valuable insights and experiences that will serve me well in the future. Furthermore, in writing up this thesis I have had opportunity to explore some ideas about what may have helped to bring about change and these are the recommendations I propose here.

The following are recommendations that on reflection could have facilitated change and are considered here solely for the purposes of my own continuing professional development. They are proposed in the light of my experience as a team member in Reablement and have not been submitted to the Healthcare Trust.
RECOMMENDATIONS

Structural Changes

It is necessary to clearly delineate the therapy focused Reablement Service from that of a medically orientated Day Hospital. There are various options available that could be implemented. This would change the way in which the Reablement Service is delivered. These options are discussed here:

Option 1

1) Dividing the Reablement Service

One way forward would be to split the service into a Day Hospital and an Outreach Reablement Team. This would create a long term medically focused facility alongside a short term therapy focused Reablement Service. The medical bias would be directed where it is most needed, into the care of the elderly-frail in a Day Hospital. Whilst the more able older adults and the younger population, requiring less medical input, could be best served by outreach work, undertaken by Reablement. Any medical needs for the Reablement patients being served by the patients own G.P. This would help to resolve some of the difficulties experienced by the staff, in that Reablement would then become truly therapist focused. This would be in keeping with the job descriptions of the therapists and create the innovative service to which they were recruited.

The problems with this option are that this would necessitate the employment of more staff to facilitate this way of working. The sharing of limited accommodation would be problematic and similarly this raises issues over the sharing of multidisciplinary team notes. In addition, this could create confusion for referrers as they would need to consider whether the patient referred needs long term help or is more suitable for a short term therapeutic intervention Reablement would offer. Some patients may be in need of both services concurrently, e.g. a patient with medical day-care needs requiring additional
physiotherapy or psychological support. This may lead to difficulties in implementing and organising service delivery. The duplication of administrative tasks could also potentially increase communication problems.

This option is in need of further refinement if it is to be implemented and cannot be recommended in its current form.

**Option 2**

2) *An Outreach and Assessment Centre*

One option would be to retain the present Day Hospital facility for the treatment of long term patients with medical needs. The advantages in this option would be in clearly drawing the distinction between Reablement and Day Hospital services, thus emphasising their separate identities. This would be advantageous as the Day Hospital is situated in a general hospital setting that does not lend itself well to community care and outreach work.

Reablement would therefore have a bridging role to play in offering care, monitoring and support in the community. It can also act as a point of communication between the hospital based medically orientated Day Hospital and other services in the community, e.g. District Nurses. The distinction of the Reablement Service as a separate service could then be achieved.

This is the option recommended in this report.
To facilitate this preferred option a number of difficulties and issues need addressing these are as follows:

Management and Co-ordination

A management support structure should be in place, with a clear vision of the service and what purpose it serves. The appointment of a Project Manager and/or Team Co-ordinator (Overeit, 1989) would be of considerable value, this is most strongly recommended. It would be envisaged that having completed the first year in operation this post could be revised.

The need for a pro-active management has been demonstrated from this report. It is argued that an experienced person from a therapist rather than medical background would be the most suitable candidate for Project Leader. This would allow for the original concept of a therapist lead, medically supported team to develop. Of critical importance is that the appointed person should be properly briefed regarding the concept of Reablement and has a clear vision of the development of the service. Although, this creates the need for extra funding for a managerial post. It is argued here that to optimise the Reablement Service this post is an absolute necessity. In addition, this postholder would be an invaluable asset in the successful implementation of plans to expand the service.

Team Style

A strong recommendation is that the team should be one of Core and Associate membership (Ovretveit, 1990). A clear definition of the core members is recommended together with a definition of responsibilities and duties and how those differ from associate membership. Team members appointed need to be experienced and of a senior enough level to defend their own professional territory and standing in a team setting. The professional emphasis should be on their own profession, secondly to the team, to avoid
problems of over-enmeshment in the team. Professional supervision and guidance should come from within members own professional discipline.

Issues of Team Conflict

Having established the preferred option for service provision, it is advocated here that the damage already incurred by unresolved team conflict should be addressed as a matter of urgency. This should be most appropriately dealt with by the use of outside resources rather than in-house facilities. It is suggested here that an external agency be employed to help the present team resolve their difficulties. Furthermore, team building should be built into plans for the service over the next year. A suitable approach to team building (Iles and Auluck, 1990) will require an experienced professional. This would help team members to resolve the conflicts that exist (Tjosvold, 1989, Adirondack, 1992).

Team Working

It is recommended that for this team multi-agency working is more appropriate than multi-disciplinary working. This subtle shift in emphasis would enable professional boundaries to be drawn, allowing for some basic skills training inter-professionally whilst each profession individually maintains its own high profile and identity. This would resolve the issues of confidentiality and responsibility regarding the keeping of multi-disciplinary team notes. It is questionable whether the notes from other team members are of significant use to any other team members. Possibly all that is needed is a simple communication system, giving minimal information.

Role Clarification

To facilitate team working the role and identity of Reablement in the community should be clarified. The patient criteria needs to be more specific. One of the concerns by the staff was the propensity for generic working which would de-skill some of the highly trained staff who had specialised in working with the elderly (Reiman, 1989). This problem could
be overcome with further training and professional development which would be helpful in increasing knowledge and skills in more specific areas. It would therefore seem inappropriate to include other specialisms such as Learning Difficulties into Reablement Service remit without any further training for staff. This is primarily because of the risk that members would not have the skills to deal with this specific group and therefore could experience further de-skilling. De-skilling would compromise current staff, leading to difficulties in retention and future recruitment.

Terms of Employment

Because there has been much strife regarding the suitability of individuals to the Reablement Service the terms of employment for each member should be made clearer. If a core and associate team model is adopted the core members would be the qualified service providers or professionals and the associate members the generic support workers. The terms of employment should be comparable for all the professionals working in the team, similarly parity between the generic workers would be desirable. Job descriptions including a job profile and personal specification, outlining core skills, are necessary to attract high calibre, appropriate staff (Adirondack, 1992). Desirable qualities for professional staff would be an independent practitioner with a demonstrated ability to work within a team; having good communication skills, an understanding of professional boundaries and a commitment to care in the community. Having up-to-date knowledge of current legislation and experience in their own profession would also be desirable. Personal specifications (Adirondack, 1992) based on these desired qualities need to be formulated.

Conditions of Service

The salary scale should reflect experience and skills brought to the team, from past experience of multidisciplinary team working as well as from their own professional expertise. Professional expertise in the field of Reablement may be difficult to find, however, similar experience can be gained from many other areas of work. Recruitment
and retention of staff are paramount in the running of any service reliant on team work and should be seriously addressed at higher levels of management (Adirondack, 1992, Rakich et al, 1992).

Furthermore, contracts of employment and conditions of service should include a recruitment policy and even more importantly a retention policy. Grievance procedures, insurance, travel expenses, relocation packages and complaints procedures also need verification from the Personnel Department (Adirondack, 1992).

**Operational Standards and Procedure**

Identification of quality standards for office procedures, internal and external methods of communication, e.g. computers, telephones, fax are needed. Operational procedures, well thought through and appropriate could be negotiated with the Reablement Team. Time spent together in planning the operational policies would be valuable as team building exercises (Lieboweitz and De Meuse, 1981). The use of an outside facilitator could enhance this process (Tjosvold, 1989). Ideally, all members of the Reablement Team need to be on board before team building can be maximally effective. The time needed to bring a team into the making is not to be hurried or pressured. It must be recognised that considerable time is needed to develop, plan and structure a new service (Maddux, 1990). It is recommended here that the current team sets aside one day per week for team building starting by focusing on the practical aspects of office procedures and standards. This valuable time spent needs to be for a minimum of three months, after which it should be reviewed.

**Future Planning**

With respect to the proposed expansion of the service, in-depth market research and detailed business planning (Adirondack, 1992) needs to be undertaken first to identify the unmet needs in community care. The pressure for the Reablement Team to meet those
needs is an issue for discussion within the Healthcare Trust Board. Market research could be helpful to the purchasers, as well as the Healthcare Trust, helping to identify where resources would be best allocated and located (Maddux, 1990). Prior to setting up a new service, the need for that service to exist has to be clearly demonstrated. This would enable successful business plans to be implemented based on relevant information (Rakich et al, 1992), which facilitates the setting up of any service.

A business plan for a Day Hospital and separate Reablement Service could be drawn up to clearly mark out the boundaries between the two services. The plan should include details of the resources needed to perform the work and clearly identify the target population. The plan should also clearly demonstrate how the Day Hospital and the Reablement Service will compliment each other, as well as the pre-existing services available already.

The impact of any new service upon other parts of the organisation should be carefully evaluated in order to prevent duplication of services and consequent wasted resources. An evaluation of the strengths, weaknesses, opportunities and threats to the service should be undertaken for Reablement, as well as outcomes measured in terms of cost effectiveness (Rakich et al, 1992).

**Concluding Remarks**

Much has been learnt from this salutary experience that will be valuable for all those that were involved. The team were to be commended for their determination and organised approach to helping resolve the difficulties. Clearly, the primary problem has been one so often reflected in MDT work in that insufficient preparation, teambuilding and management lead to the medicalisation of a therapeutic service. This had been compounded greatly by the lack of an appointed leader, unclear specification regarding the style of team and its appropriateness for meeting the needs of the patient population. Furthermore, the purchasers having attempted to be very prescriptive regarding the need for a Reablement Service have not been helpful in stipulating the patient criteria, thus,
without a clear remit for the service, problems emerged. Indeed, it may also be said that as the term Reablement has no clear definition it is open to abuse by those wishing to create a generic all encompassing service. In retrospect, many of the problems could have been avoided with careful management, especially in the formative stages. With hindsight, it is clear that given the prevailing circumstances most of the problems encountered were therefore, unavoidable.

EPILOGUE

Because of the difficulties the team members experienced and the significant levels of distress incurred, two of the members (myself, and the Occupational Therapist) have since resigned our posts and returned to our areas of origin. One local member (the Nurse Practitioner) has taken a post elsewhere and of the two remaining therapist members, the Physiotherapist took another post with the Healthcare Trust and only the Speech and Language Therapist remains. The team as it exists now is overseen by a Nurse Manager, a move which has radically reduced the influence of the medical members in the team and lead to an improvement in professional standards and ethical behaviour. As yet, there has been no further initiatives regarding the setting up of another Reablement Service elsewhere.
REFERENCES


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APPENDIX 1

TEAM BUILDING DAY

PROGRAMME

9.00 Coffee

9.30 Discussion: Roles and boundaries in the Team

11.00 Coffee

11.15 Talk by the Purchaser Representative

12.30 Lunch

1.00 Discussion: Patient Criteria

2.00 Informal Discussions

3.00 Coffee

4.00 Summary of the Main Points

5.00 Close
REABLEMENT WORKSHOP

PRESENT:  Director of Operations
          Director of Nursing

The Steering Group                      The Reablement Team
Occupational Therapy Manager     Occupational Therapist
Consultant Physician            Clinician for the Elderly
Physiotherapist Manager         Physiotherapist
Clinical Psychology Manager     Clinical Psychologist
Nurse Manager                   Nurse Practitioner
Speech and Language Manager    Speech Therapist
Physical Medical Manager        Co-ordinator

REABLEMENT WORKSHOP AGENDA

9.00  Coffee

9.30  Desired characteristics of a Reablement Service

10.30 Team style

11.30 Client Suitability

12.30 Close
SECTION FOUR: RESEARCH AUDIT
STUDY ONE

Coping after Breast Surgery

Submitted in partial completion of the PsychD in Clinical Psychology

University of Surrey, 1997
INTRODUCTION

“Women who have had a mastectomy........................ are forced to present themselves falsely in all situations, having to conceal their unconventional secrets because of everyone’s having to conceal the conventional ones.”
Goffman (p 95, 1963)

Breasts play an important role in the sexual lives of women and their partners with most women setting great store by the acceptance of their bodies as sexual objects (Boston & Louw, 1987). Media representation in western society has emphasised the form, contour and shape of the breast and this is culturally identified with female sexual attractiveness. Consequently, when breast surgery affects such an important body part it can have a devastating effect upon how women cope with their lives. This study of women investigates breast surgery as a major life stressor. The primary focus of this study hinges on the way in which women cope with their lives' post-surgery. This study seeks to investigate the physical and psychological impact of mastectomy and lumpectomy surgery. Part of the problems following surgery of this kind revolve around having a compromised sense of body image and these problems are highlighted. Similarly, attention is drawn to other possible stressors as part of the process of treatment women receive, such as radiotherapy and hospital follow-up appointments following surgery.

The Prevalence of Breast Cancer
Breast cancer claims the lives of 15,000 women per annum in the UK and is the leading cause of death in women aged 35-50 years (Dean, 1988, Fallowfield & Clark, 1991). It is one of the most common cancers of modern times (American Cancer Society, 1993). The survival of breast cancer is dependant upon early detection, diagnosis and treatment. An increase in breast awareness and the advocating of self-examination has lead to a parallel increase in the early diagnosis and treatment of breast cancer. For these reasons, Veronesi

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& Zurrida (1996) commented that breast cancer is becoming curable in a high proportion of cases and attention is now turning towards the aesthetic outcome of surgery.

However, some concern is currently being expressed over the higher numbers of breast cancer being detected by mammography and it is suggested that the proportion of cases treated by mastectomy may be inappropriately high (Ernster, Barclay, Kerkikoske, Grady & Henderson, 1996). It is suggested that surgeons are being over-cautious in their interpretation of mammography results leading to women having breast surgery for pre-cancerous conditions. Further to this there are now moves towards prophylactic mastectomy in preventing breast cancer in women described as being high risk (Lopez & Porter, 1996). These factors have greatly increased breast surgery rates and may contribute significantly to more women surviving breast cancer today than ever before. This makes research into the psychological sequela of breast surgery doubly important.

**Different Surgical Techniques**

Currently, two surgical techniques are in common use: simple mastectomy, which involves the complete removal of the breast, and breast conservation surgery that is often called sector mastectomy or lumpectomy. The latter is favoured, where it is surgically possible, since McWhirter (1955) first demonstrated the operation's effectiveness when combined with radiation therapy. It will only be performed however, if the cancer is localised to one area of the breast. With the increase in early reporting of breast cancer, lumpectomy is often chosen in preference to mastectomy. For the purpose of this study the term mastectomy will be used to describe simple mastectomy and lumpectomy will refer to sector or partial mastectomy.

For some women the option of breast re-construction may be possible. As yet, this option is not widely available on the NHS and therefore there is little research into this area. The
two methods of breast re-construction are described by Ivey & Gordon (1994). Commonly, silicone implants are used, or less commonly, the patients own tissue, taken from a donor site such as the stomach or thigh. Knobf & Stahl (1991) suggested that factors determining which method of re-construction is best suited are based on predicted outcome, patient expectation and patient risk associated with surgical complications. Thus, this is not an option of choice for some women. Anderson, Rodin & Ariyan (1994) reported that women were more likely to request re-construction surgery if they were concerned generally with their appearance and body image. Those women, who are able to benefit from breast re-construction often request it because they find a prosthesis repugnant and demeaning. Therefore, this operation has a lot to offer some women (Reaby & Hort, 1995).

Recent work has fuelled the debate as to the least traumatising kind of surgery. Many argue that lumpectomy preserves a more intact body image than mastectomy (Wellisch, Dimatteo, Silverstein, Landsverk, Hoffman, Waisman, Handel, Waisman-Smith & Schain 1989, Noguchi, Saito, Nishijima, Koyanagi, Nonomura, Mizukami, Nakamura, Michigishi, Ohta & Kitagawa, 1993, Schover, 1994). However, Maguire (1989) and Meyer (1989) commented that the reduction of body image problems in lumpectomy may be offset by an increased risk of anxiety regarding recurrence of the disease. A recent review by Fallowfield (1990) of ten studies comparing the psychosocial outcome of mastectomy with lumpectomy plus radiotherapy revealed that lumpectomy is more protective of psychological disturbance than mastectomy. However, she pointed out that women still have to cope with the fact that they have had a life-threatening disease which may recur, which explained the lack of difference in psychiatric morbidity between the two groups. de Haes & Welvaart, (1985); Gotteschalk & Hoigaard-Martin, (1986); de Haes, van Oostrom & Welvaart (1986) all reported that lumpectomy is less mutilating and often produces a better cosmetic result than mastectomy, therefore promoting a better physical and psychological outcome. Although, women who of their own volition choose to have mastectomy fail to appreciate the likely extent of the disfigurement this operation causes (Margolis & Goodman, 1987).
Mock (1993) indicated that lumpectomy patients were significantly more positive in attitude than mastectomised women or those having undergone re-construction surgery. However, lumpectomy has received some criticism from Hilner (1996) who concluded that these women have a slightly higher risk of death than women who have a mastectomy. Therefore, the value of lumpectomy needs to be offset against this increased risk.

Richards (1996) commented that mastectomy rates have decreased from 52% to 28% in some geographic areas of the UK in favour of lumpectomy surgery. However, Nattinger, Gottlieb, Hoffman & Walker (1996) report a minimal increase in lumpectomy procedures in their study in the USA. This would indicate that what women are offered is often dependent upon where they reside and the cultural ethos of the hospital in which surgery takes place. This is coupled with the skill and expertise of the surgeon and their preference of surgical technique.

Dowden & Yetman (1992) reviewed the literature on immediate breast re-construction following mastectomy. The psychological advantages of immediate breast reconstruction are well understood in the elimination of many aspects of the psychological trauma of mastectomy. These authors suggested that if breast reconstruction was considered as a viable option this may encourage more women with breast lumps to come forward for treatment. Rowland, Holland, Haglassian & Kinne (1993) highlighted the overwhelmingly positive effects of re-construction and showed the need for more research into who seeks re-construction, why, and impact on post-mastectomy functioning. An evaluation by Eberlein, Crespo, Smith, Hergreuter, Douville & Eriksson (1993) concluded that reconstruction can be performed safely and with excellent cosmetic results.

The way forward may be shown by Carlson (1996) who advocated the use of skin sparing mastectomy for patients treated by mastectomy with an immediate breast reconstruction. This greatly enhanced the aesthetic result of breast reconstruction. However, this relatively new technique has, as yet, received scant attention in surgical literature.
Psychological Morbidity

An early study by Maguire, Lee, Bevington, Kuchemann, Crabtree & Cornell (1978) reported many psychological problems being experienced by mastectomised women. They found that at least one in four women who undergo mastectomy is likely to develop an anxiety or depressive state within the first post-operative year. 25% of subjects had a moderate or severe level of anxiety or depression compared with 10% in the control group. Similar findings have been reported by Morris, Greer & White (1977) and more recently by Dean (1988). Lasry, Margolese, Poison, Shibata, Fliescher, Lafleur, Legault & Taillefer (1987) found more affective disorders amongst those women having had mastectomy compared with those having had lumpectomy. However, Maraste, Brandt, Olsson & Ryde-Brandt (1992) reported that emotional distress is characterised by anxiety rather than depression following mastectomy.

Jamieson, Wellisch & Pasnan (1978) reported high incident rates of suicide as well as tranquilliser and alcohol abuse in women following mastectomy. They concluded that these problems stem from anxiety and depression, the causal factor of which is perceived loss of self esteem and reduced feelings of femininity after mastectomy. De Leo, Predieri, Melodia, Vella, Forza & de Bertolini (1991) found more marked suicide attitude in mastectomised women than control groups of medical patients and healthy subjects. Recent work by Pasquali (1993) indicated that as a consequence of mastectomy women experience disruptions in four domains of life: the physical, the psychological, the social and the spiritual that may explain the high psychological morbidity rate. He referred to this as the Mastectomy Trauma Syndrome and advocated a holistic approach to care encompassing the physical, social, spiritual and the psychological aspects of each individual.

The possibility that personality factors such as extroversion and neurotisism may have a predisposing role in diseases such as breast cancer have been discussed over recent years. The notion surrounding this idea was that cancer may be linked to premorbid behaviour.
type or personality. Early studies such as Esler & Goulston (1973) and Palmer, Stonehill, Crisp, Waller & Misiewicz (1974) reported higher levels of neurotisism and anxiety with some irritable bowel syndrome (IBS) patients, although these early studies are not methodologically sound. However, much of the research indicated there may be a link between personality and the aetiology of cancer. Later, this was investigated by Eysenck (1986) who outlined a model of causal theory linking personality to cancer. This author maintained that hormones and peptides produced in the body influenced personality and proposed that personality and life stress may be related to the suppression of the immune system leading to the development of diseases such as cancer. This was further discussed by Eysenck (1988) who highlighted the interacting factors such as stress, personality and other psychosocial factors may interplay to predispose an individual to cancer. Broome (1989) also drew attention to this interplay between personality, stress and the psychological reaction to illhealth and medical problems such as breast cancer.

Nairne & Smith (1984) maintained that such a major life stressor as breast surgery must have a negative effect upon self esteem, thereby creating a propensity for depression in either group of women. Psychological problems such as low self esteem and body image distress have been known to persist for many years (Hopwood & Maguire, 1988). These authors maintain that evaluation of such problems is limited by the lack of data in this field of research. They proposed that this may be because patients are reluctant to disclose their feelings, or because psychological help is not offered as distress is considered a natural reaction following surgery. Fallowfield (1990) commented on how the hopes that lumpectomy would protect women from psychological morbidity have not been realised. This is possibly because of the greater fears this group have about recurrence of the disease (Maguire, 1989, Meyer, 1989) and the fear that they would then need further more radical surgery. In addition, it may also be said that psychological help is not always available following surgery. Yet, for many women the psychological problems are very real resulting in a reduction of quality of life (Bergland, Fornander, Rutqvist & Sjoden, 1991).
Age Factors

Scant attention has been given to the relationship between the effects of age and coping after surgery. Maguire (1975) suggested that age may be an important factor in the psychological recovery from breast surgery. Bloom (1982) and Bloom & Spiegel (1984) found that age was not a variable affecting post-surgical well-being. However, in an earlier study Meyerowitz (1980) found less psychological distress in older mastectomised women compared to younger women. Some explanation of this difference emerges in a study by Mertzger, Rogers & Bauman (1983) who reported greater fears of disfigurement in younger women. Furthermore, Schover (1994) in a review of the literature reported that younger pre-menopausal women are the most devastated by mastectomy, displaying more severe emotional distress than older cohorts.

Although younger women may be more vulnerable to emotional distress regarding their body image, their generally higher levels of fitness make recovery from surgery easier. This ease of recovery may mask the psychological impact of surgery from professionals, friends and family (Winick & Robbins, 1977). Thus, in younger women the impact of the trauma may become hidden. On the other hand, Willets (1994) drew attention to the emotional distress experienced by older mastectomised women which is often ignored by professionals, friends and family.

Marital Relationships

Al Issa (1980) reported a general trend for divorced and separated women to be more depressed than those women who were married or living with a partner. Thus, women who are in established relationships may cope better with the physical and psychological consequences of mastectomy. Conversely, Bloom (1982) and Bloom & Spiegel (1984) reported that psychological well-being is not related to marital status in mastectomised women. In this context Metzger et al (1983) found that married women were less
concerned than unmarried women about physical disfigurements following breast surgery. Omne-Ponten, Holmberg, Burns, Adami & Bergstrom (1993) reported that living with a spouse or partner seems to protect mastectomised women from developing psychological and social problems post-operatively.

The quality and closeness of an established marriage or relationship would also seem to have a bearing on how women cope following mastectomy. Hughes (1987) reported that marital satisfaction was sometimes enhanced following mastectomy, due to couples drawing together in this time of need. Nonetheless, the more fragile or antagonistic the relationship the more likely it is to break down under the strain imposed by breast cancer (Fallowfield & Clark, 1991). Moreover, these authors noted that coping with the long term adjustment following breast surgery is greatly influenced by the quality of the support offered by the partner.

**Psychosexual Difficulties**

Jamieson, Wellisch & Pasnani (1978) and Derogatis (1980) reported similar findings, that sexual functioning is considerably compromised following surgery of this kind. Derogatis considers body image and sexual functioning to be interrelated aspects of self image, which if accepted could account for the disproportionate impact of breast surgery as compared to other types of surgery, on the concept of self. This work is supported in earlier research by Maguire et al (1978) who found 33% of their sample who were sexually active had sexual problems following mastectomy. These patients reported a deterioration in sexual contact over time leading to avoidance of sexual contact with their partners.

Thus far, research is scant into how husbands and partners cope with the patients scarring and breast loss. A descriptive study by Northouse (1989) assessed the concerns of patients and their partners finding that most partners coped well with the surgical scarring although a few partners found this a difficult experience. The quality of life and self-esteem of the
patient is often dependent upon their partners reaction to their altered body state, a negative reaction can lead to marital and sexual difficulties in the relationship. Ofman (1992) reviewed sexual dysfunction in cancer patients drawing attention to a heightened awareness in patients regarding their quality of life. Ofman advocates that improved surgical techniques that are less mutilating and sympathetic methods of sex therapy are needed. Further investigation from researchers in these areas may enhance the quality of life and self-esteem of mastectomised women.

Schover (1994) reports on the effects of mastectomy in pre-menopausal women, with younger couples being significantly more distressed than older couples. This may be related to lack of self esteem and body image problems. Similarly, young single women felt distressed about seeking new partners following surgery because of their scarring and poor breast appearance. Furthermore, infertility is also a problem for young mastectomised patients, owing to the follow-up drug therapies and radiotherapy which has implications for those wishing to have a family.

Loss of Femininity
Interrelated to psycho-sexual functioning is a woman's perception of her own femininity. Breasts are a visible sign of femininity argued Polivy (1977) who reported on the psychological trauma caused by mastectomy. Polivy showed that femininity and self-esteeem are interrelated, distress and perceived loss not appearing until some months after surgery. The only in-depth study on perceived loss of femininity has been conducted by Hopwood & Maguire (1988) who examined distress caused by mastectomy in respect to loss of femininity. They argue that femininity is an important aspect of a women's body image. Their subjects described themselves as "feeling like half a woman" and "being a freak" with considerable feelings of jealousy reported by some women towards other women with two breasts. Moreover, although lumpectomy has been thought to be
protective of a woman's body image and self esteem, Nelson (1993) reported no significant differences between the two groups in terms of perceived self esteem.

Schain, (1988) stated that women who gain their self-esteem from physical beauty and traditional values of femininity are more likely to be devastated by mastectomy than women who do not. The importance women place on defining their femininity through their breasts is a cultural factor that potentially has a devastating effect upon self-image, sexuality and perceived attractiveness to others. Clearly, there is room for more research into how women cope with a compromise of their perceived femininity after mastectomy.

**Body Image Problems**

Fear of death from cancer is only part of the problem experienced; women also cope with a future of physical disfigurement that has psychological consequences. Part of the distress caused by mastectomy is the disruption to body image. The preservation of an intact body image following breast surgery is therefore an important issue after mastectomy. Samonds & Cammermeyer (1989) suggested that long term disease allows for adaptations to perceived body image, which must facilitate coping. This must be different for those who experience a sudden onset of a physical problem such as breast cancer.

Research into the use of prosthetics in this population seems inadequate given the numbers of women effected each year. It can be said that a prosthesis only convinces others of an intact body, not the wearer herself (Goffman, 1963). Further to this, Kaplan (1983) reported on psychological distress as a direct result of a person having subjectively perceived circumstances that they are devalued, such as may be caused by the wearing of a prosthesis. This is a much neglected area of research in this very high profile field.
For the purposes of this study body image will be defined as the subjective concept of one's own body, specifically in respect to evaluating judgements concerning how one is perceived by others and how well one adjusts to those perceptions (Reber, 1985). This definition can be used in respect to physical appearance only or include other aspects of body image such as movement, function and co-ordination. In the present study it will be used to refer to physical appearance.

Coping with Treatment Processes

Shortly after recovery from the operation itself most women undergo radiotherapy to remove any remaining cancerous cells that may still be present, how women cope with this has never been addressed. Anxiety at the start of a course of radiotherapy in breast cancer patients has been noted by Maraste et al (1992). The results of this research indicated that emotional distress is characterised by anxiety rather than depression at this time. An earlier study by Maguire (1989) reported on the fact that the role of radiotherapy is as yet unclear and the link between psychiatric morbidity and adverse effects of radiotherapy are not satisfactorily explained.

More recently, Berglund et al (1992) reported in their study that those subjects having received radiotherapy had significantly greater problems with decreased stamina, anxiety and problems relating to the operation scar. There is a dearth of literature examining the psychological effects and impact of radiotherapy and this may be an under-estimated source of distress.

Each woman is followed up for a minimum period of five years following breast surgery for cancer. On a regular basis the women attend the hospital for regular check-ups with their surgeon and oncologist. The psychological problems encountered with these follow-up sessions have not been addressed in the literature. The follow-up sessions may serve as a constant reminder of cancer and how it may recur. Polinsky (1994) indicated how
distressing women found the medical follow-up appointments, a factor that did not diminish over time.

The continued distress women feel many years after their operation has been commented upon and the lack of structured formal and organised help has received much attention over recent years with the development of Cancer Support Groups and similar organisations which are primarily offered from the voluntary sector. There has also been a move towards offering help to mastectomised women post-surgery with the advent of the Breast Care Nurses. Crockford, Holloway & Walker (1993) highlighted the perceived lack of counselling skills in nurses and the absence of specialised counsellors and nurses who could help women cope with the long term psychological effects of surgery. Although, recent advances have lead to innovative programmes for breast cancer patients such as Reach to Recovery (Willits, 1994). This successful programme is a more structured and sophisticated form of many voluntary services offered for breast cancer sufferers.

Feather & Wainstock (1988) suggested that mastectomised women have educational needs such as, more information on breast cancer, exercise, nutrition, weight control, more information on prostheses and suitable clothing, social support and sexual issues. The findings revealed that the main source of information provision was via the media. Few women indicated that they attended at specialised support groups. Furthermore, information seeking was most often encouraged by work associates with health care professionals being the most successful in encouraging women to attend support groups.

Social Support

Breast surgery can be particularly traumatic for women who have little or no emotional and social support from significant others. The importance of social support for women has been stressed by Brown & Harris (1978). Feather & Wainstock (1988) emphasised the
importance of emotional (as opposed to tangible) support from others at times of crisis, such as when women undergo breast surgery.

Zemore & Shepel (1989) argued that when social support is needed most it is often found wanting, this results in self-doubt increasing psychological distress. These authors found that emotional support from family and friends was positively correlated to adjustment post-mastectomy. Levy, Haynes, Herberman, Lee, McFeeley & Kirkwood (1992) drew attention to the greater emotional needs of younger mastectomised women, these authors stated that younger patients required more social and emotional support than older patients to cope with the surgery and its impact. They pointed out the emerging evidence that emotional support may act as a stress buffer and this may have a role to play in survival of the disease.

More recently, Payne, Sullivan & Massie (1996) documented the experience of breast cancer and the variety of emotional responses to the disease. Of considerable importance is the social, emotional and financial support of others and the ability to cope with adverse life events. Emotional responses will also vary dependent upon pre-operative psychological well-being, parameters of the disease and general coping ability.

An important aspect of social support is the quality of emotional support gained from the marital relationship. Omne-Potent et al (1993) investigated the psychosocial adjustment among husbands of breast cancer patients that has implications for the continued social and emotional support of the patient. Their findings revealed that 48% of the husbands expressed emotional distress and depression that is similar to levels reported by the women themselves. These authors reported that there were no marked differences between husbands of mastectomised women and husbands of women having had a lumpectomy. This finding has implications for the psychological welfare of patients because husbands are clearly not coping well with their wives' illness. This is an under-reported area of considerable distress that has yet to be fully appreciated or addressed in the literature.
Cognitive Factors

The role of cognitive factors in coping with mastectomy has never been directly addressed by researchers. Horowitz (1986) developed a cognitive processing model to explain what happens when a traumatic life event, such as breast surgery, challenges an individual's cognitive schema about their world. He proposed that the integration of new material into the pre-existing cognitive schema is needed if individuals are to recover from the effects of a trauma. It is suggested that the pre-existing schema has to be modified by emotionally processing the new material and integrating this into the schema. The traumatic event is stored in active memory until such time as it becomes integrated into the schema. Whilst in active memory the traumatic information or event may produce intrusive and uncomfortable cognition's that can lead to anxiety, depression and other psychological problems frequently shown in breast cancer patients.

McFarlane (1992) discussed the role of cognitive factors and the link between traumatic life events and psychopathology. This researcher looked at the impact of a natural disaster by measuring two components of Post Traumatic Stress Syndrome. The two components "Intrusion" and "Avoidance" he identified as having an important role in the integration of painful and traumatic events into the pre-existing schema. His findings revealed that "Intrusion" was mediated between the life event and psychopathology whilst "Avoidance" limited the distress encountered by the re-experiencing of the event in active memory.

The impact of a traumatic life event has been investigated by Creamer, Burgess & Pattison (1992). These authors proposed a five stage model that offered an explanation of cognitive mechanisms involved in the processing of a traumatic event. Cognitive processing of the traumatic information would then lead to recovery. The model is based on: objective exposure; network formation; intrusion; avoidance and outcome.
Coping with Mastectomy

Many studies such as Morris, Greer & White (1977) and Maguire et al (1978) have reported on the psychiatric and psychological problems found in mastectomised women. For some women the problems persist with time. It would seem reasonable to assume that problems will change over time as the necessary psychological adjustments are made. There exists the possibility that some problems will increase rather than decrease over time. The long term effects of breast surgery have been reported by Polinsky (1994) who demonstrated the chronicity of psychological sequelae. Subjects reported continued concern about recurrence and its long term effects up to 32 years following surgery. The data revealed that time factors were irrelevant to the level of concerns.

As early as 1977 Polivy found that patients use denial as a defence or coping mechanism immediately following surgery. She reported that as some psychological problems may not manifest for some weeks or months after surgery it may be months before denial is no longer required as a defence mechanism. It is argued here that denial may be used as a coping strategy by some women indefinitely after breast surgery. Indeed, in a longitudinal study by Heim, Augustiny, Schaffner & Valach (1993) breast cancer patients were followed up regularly over a 3-5 year period. Their results confirm that women used different ways of coping, such as denial, at different stages of their illness and long after surgery.

The effects long after surgery are reported by Maguire et al (1983) who found women unhappy with their mastectomy scar and continuing to feel distressed by the mutilation. Distress was particularly felt over seeing their naked reflection in mirrors. Such distress led to avoidance behaviour such as getting dressed and undressed in the dark and avoiding bathing and showering. Many women described themselves as feeling physically "uneven" or "lopsided" following the loss of the breast, sensations that did not abate over time. Hopwood & Maguire (1988) reported on how women cope with the physically mutilating effects of mastectomy. Their findings reveal that women can experience a real sense of
permanent change to their body that they feel unable to overcome. Women reported wanting to disassociate the mutilated part of their bodies, avoiding contact with or looking at the site of the operation.

Mastectomised women must also cope with grief and mourning for the breast itself. Maguire (1990) reported that many women are not asked how they feel about losing their breast possibly because of a professional reluctance on the part of surgeons. When women undergo mastectomy they are usually offered a prosthesis (false breast) which is worn as a replacement body part. It is necessary for women to be professionally fitted for the prosthesis and how women cope with this has yet to be addressed by researchers.

Indeed, very little research to date has been carried out into how women cope with wearing a prosthesis. Maguire et al (1983) reported that 24% of women were discontented with their prosthesis that suggested that some women do not cope with wearing a prosthesis. A prosthesis is most frequently viewed as a foreign object and a constant reminder of cancer. The consequent sense of deformity and disfigurement is reported by Luckman & Sorenson, (1987) as well as Bostwick, (1989). However, an extensive study comparing women who wear an external prosthesis with women having lumpectomy was conducted by Reaby & Hort (1995). Their findings indicate that women in either group reported being satisfied with their bodies and displayed a positive outlook on life. Although, the authors commented that in order to cope with their situation negative attitudes may be being denied. Therefore, using denial as a coping strategy is in their own best interests. They discussed this in relation to cognitive dissonance theory (Kaplan & Sadock, 1985) that any dissatisfaction voiced or acknowledged may prevent them from coping with their life.

Ali & Khalil (1991) identified five stressors amongst mastectomised women as, a hope for a cure, effective treatment, fear of the unknown, disease progression and pain. These authors reported that faith, information seeking, medical compliance, social support and
self-distraction were coping strategies employed in order to deal with the identified
stressors. Further to this, a study by Wong (1992) related the stress of continually living
with the uncertainty of recurrence of cancer with anxiety state. Wong called for the
development of appropriate interventions to help women cope with fears about recurrence
and the stress of an uncertain future. Heim et al (1993) studied coping over time in breast
cancer patients. They found that coping strategies became more varied over time with
three constant dimensions: support and acceptance; denial and distraction by thought and
action.

Denial as a coping strategy has also been reported pre-operatively by Jelicic, Bonke &
Millar (1993). In this small scale study anxiety was reportedly low in some patients, the
authors suggested that these patients used denial as a coping strategy against the stress of
major surgery. However, Reaby et al (1994) and Reaby & Hort (1995) reported a more
positive attitude following mastectomy than in a control group of women who had not
experienced breast surgery. However, it is argued here that this counter-intuitive finding
may be explained by the continued use of denial post surgery in keeping with the earlier
work of Kaplan & Sadock (1985).

Coping styles have been investigated extensively with the primary focus of the literature
being upon coping with surgery using pre-operative subjects. The way in which women
cope post-operatively with the long term consequences of surgery has not received the
same interest. Various theoretical models have been proposed such as emotional-drive
theory (Janis, 1958) and self-regulation theory (Leventhal & Johnson, 1983). In brief,
emotional-drive theory suggested that patients undergoing surgery must do the ‘work of
worry’ (Janis, 1958) in order to cope with the operation or surgical procedure that they
are to undergo. Whilst self-regulation theory involved the concept of cognitive schemata,
guiding and directing incoming information which facilitates coping with surgery. Clearly,
these models of coping have much to offer in terms of explaining coping with impending
surgery, however, they cannot be easily applied to coping with the long term physical and

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psychological consequences after surgery. A model of coping that offers a framework for coping post-surgically is cognitive appraisal theory (Lazarus & Folkman, 1984).

This theoretical concept proposed by Lazarus & Folkman (1984) rests on their model conceptualising coping into two broad categories or styles: problem-focused ways of coping and emotion-focused coping. Problem-focused coping is the direct actions by a person to avoid, modify or minimise the impact of the problem experienced. In this way the problem is dealt with by attempting to control the threatening situation. Emotion-focused coping is the avoidance of the problem encountered. Avoidance is used to reduce the emotional upset or distress experienced. This may be by using denial, distraction or avoiding direct confrontation of the issues. This model assumes that those who use a maladaptive way of coping are more likely to suffer from anxiety and depression and can be more readily used post-surgically.

Cohen & Lazarus (1973) indicated that some patients actively seek out information ('sensitisers'), whilst others avoided doing so ('blunters'). Similarly, an earlier study by Andrews (1970) indicated that 'sensitisers' were more likely to seek out help with their problems rather than 'avoiders' who distanced themselves from their emotions. Mechanic (1979, 1980, 1983) highlighted these differences in coping styles. This author suggested that those who seek out information are 'monitors' who are more prone to somatisation of their symptoms than 'blunters' who ignore information. Whilst Mechanic showed that 'monitors' are more likely to focus on their physical symptoms, Miller & Mangan (1983), Miller, Summerton & Brody (1988), highlighted their greater demands for medical tests, information and counselling. Miller & Mangan also found that 'monitors' experienced less perceived control of threatening situations and more post-surgical physical and psychological problems.
The present study

The overall aim of this study is to draw together relevant information using a multi-methodological approach. This will be achieved by firstly using quantitative methods of data collection in the form of questionnaires and inventories. Secondly, a qualitative approach will be taken using a semi-structured questionnaire as a basis for interviewing each respondent.

Specifically the study seeks to test the following hypotheses:

1. That mastectomised subjects would have higher scores than subjects having had a lumpectomy on the following dependent variables: Beck Depression Inventory (BDI), Eysenck Personality Inventory (EPI), Impact of Event Scale (IES), General Health Questionnaire (GHQ) and the Ways of Coping Inventory.

2. Specifically that mastectomised women would report more verbal statements about negative body image than women who have had a lumpectomy.

3. That higher levels of maladaptive, emotion-focused styles of coping will be significantly related to a greater number of negative body image statements, GHQ scores, IES scores, BDI and STAI scores.

4. That married women and those in stable relationships would have lower scores on dependent variables such as BDI, IES, GHQ and STAI scores.

This study also seeks to examine the research question of breast cancer as a major life stressor. Particular attention is drawn to the ways women cope in the years following breast surgery. This will be achieved using qualitative research techniques specifically aimed at identifying the issues revolving around body image problems. In addition, information will be gained concerning experiences of treatment such as radiotherapy and the post surgery follow-up appointments. Attention will also be drawn to relevant helpful and unhelpful experiences they report since the time of their surgery.
METHOD

The approach of the study was primarily informed from the work of Lazarus & Folkman (1984) and their theoretical concept of coping. This concept as previously described is based on problem-focused coping (taking action to deal with problems) and maladaptive emotion-focused coping (using denial, distraction and avoidance). In order to investigate these concepts of coping various questionnaires were used in a straightforward quantitative approach to data collection.

However, using a traditional quantitative approach to the present study is limited, it can only inform the research about the impact of breast surgery by measuring whether respondents are depressed, anxious, generally distressed and their style of coping etc. Although quantitative information is valuable, it does not inform the research about the experiences and clinical issues that underpin what was being measured. Other researchers such as Herbert (1989), McCarl & Nielson (1990), Lawler (1991) and Meerabeau (1992) had previously found a similar difficulty in using traditional quantitative research methods in addressing a research question or problem which 'by it's very nature is hidden and where there is silence' (Lawler, 1991).

In order to gain this understanding and insight a multi-methodological approach has been employed by the present study. Using this approach allowed material relevant to the research to emerge gradually during the course of the study that cannot be reached by quantitative methods alone. This approach uses a combination of research methodologies drawn from quantitative and qualitative perspectives which allows the pertinent underpinning issues to evolve and emerge. A study by Reinharrz (1992), highlighted the need for such combined research methodologies in order to understand the critical issues in studies of women's lives and therefore this can be appropriately applied to the present study.

Therefore, the quantitative aspects of this research will be conducted by the use of a battery of tests. These tests are aimed at addressing the specific hypotheses previously
outlined. In addition, qualitative information will be collected using a semi-structured questionnaire developed for this study.

SAMPLE

This study used a sample of women drawn from members of a Cancer Support Group: respondents were obtained on the basis of self-selection. The respondents were recruited by letter ( Appendix 1). This letter was included in the bi-monthly Newsletter for the group. Of the 300 copies of the letter that were sent out 56 women replied. Thirteen respondents were unable to attend or were in active medical treatment, therefore, these were excluded from the study. Further to this, another three respondents failed to fully complete their questionnaires. All the respondents were interviewed in the same setting, this was a Resource Centre for the Cancer Support Group. With all respondents consent was sought by the researcher for participation in the study, confidentiality of the data collected was also assured.

It was considered ethical to recruit by self-selection as recalling some of the past experiences of surgery may have been distressing for some women. Lewin (1979) discussed why respondents self-select for interviews and research. Lewin suggested that there may be some altruistic reasons, such as a genuine interest in helping the researcher in their work. There may also be a desire for the respondents to talk through their own problems in order for them to gain a greater understanding of their own difficulties, by sharing the past experience the opportunity for catharsis may present. Some respondents may only wish for their problems to be heard, whilst others may use the situation to gain a break from everyday routine.

There is however, continued debate about subjects who are recruited by the process of self selection. As stated by Lewin (1979) there may be a number of reasons why respondents choose to be part of a study. Furthermore, in sharing their experience's respondents may give a biased account of their difficulties or present a particular
viewpoint they wish to express (Lewin, 1979). However, not only are there problems with respondents giving possibly biased accounts of their experiences, but the results of such research may be difficult to generalise to a wider population. Such biases and difficulty in generalising the findings are perhaps less evident when using other selection techniques such as randomisation.

The respondents were all women who had undergone mastectomy or lumpectomy surgery. Of the 40 respondents in the study, 20 had undergone mastectomy and 20 had a lumpectomy.

Respondents with a known benign diagnosed condition, those having had exploratory breast biopsy only and those having had a radical mastectomy with the removal of the lymph nodes were excluded from this study. Similarly, women actively engaged in radiotherapy, chemotherapy or further surgery were also excluded.

In all cases the women had been made aware of the kind of operation they had undergone prior to surgery taking place. None of the women had been given the opportunity to choose the type of surgery they preferred. This was at the discretion of the surgeon. In all cases consent was given by the patient for the surgery to be carried out following a discussion with the surgeon about the kind of surgery considered most appropriate for the patient. It was not the policy of the hospital involved to offer immediate breast re-construction for women having a mastectomy.

All respondents reported being aware of the kind of surgery they needed before the operation went ahead. In all respondents biopsy and mammogram tests had been used to confirm the diagnosis. All respondents reported that they had been satisfied with the diagnosis at the time of surgery.
PROCEDURE

The respondents completed standardised questionnaires, as follows: The Ways of Coping Checklist (WOC); the Impact of Events Scale (IES); the Rosenberg Self Esteem Scale (RSE); the State Trait Anxiety Questionnaire (STAI); the Golumbok Rust Inventory of Marital State (GRIMS); the Eysenck Personality Inventory (EPI); the Beck Depression Inventory (BDI) and the General Health Questionnaire (GHQ). In addition, demographic and biographic details were obtained from each respondent. All questionnaires were scored by the Research Assistant and checked by the researcher.

The main study also involved an interview with each respondent, the researcher using a semi-structured interview schedule developed for this purpose during the pilot phase of the study. This is described in more detail below, as is the way in which it was developed.

The interviews were conducted by the researcher. Because of the sensitive nature of the issues raised at interview and the semi-structured style of interviewing which allows for individual expression there is a need to ensure appropriate debriefing (if it is requested) following interviews of this kind. The use of interviews can be the first opportunity for the respondent to talk of their experiences, which may be painful to recall (Lawler, 1991). Indeed, Glesne & Peskin (1992), drew attention to the fact that there is potential for interviews to become therapeutic as respondents recall very emotional material. Therefore, each respondent was given the name and contact telephone number of a Counsellor specialising in working with breast cancer patients. By arrangement, the Counsellor had agreed to debrief the respondents if they felt this was an appropriate course of action.

To prevent cross contamination of the data such as may be caused when researchers shift emphasis from quantitative to qualitative data collection with the same sample population, the questionnaires were completed under the supervision of a Research Assistant, whilst the interviews were conducted by the researcher. The questionnaires
were initially scored by the Research Assistant and the results of the questionnaires were not known to the researcher at the time of interview.

PILOT STUDY

The questionnaires used were piloted using a random selection of women who had not had breast cancer. This was to assess the questionnaires for their suitability, comprehensibility and ease of completion. The questionnaires were then used with respondents participating in the pilot study (n = 10), to identify any other problem areas.

Each of the respondents were also interviewed by the researcher. The interviews were audio-taped, each tape was analysed using an open coding approach described by Strauss & Corbin (1990). This involved comparing the statements the respondents made relating to aspects of their body image for differences and similarities as well as aspects of treatment processes. From this comparison evolved the conceptualisation of the statements into core categories, or themes (Strauss & Corbin, 1990). A categorical working model of the issues was allowed to emerge which informed the main study and formulated the basis for the semi-structured interview schedule. However, the research was constantly alert to any necessary re-alignment of these categories during the course of the main study.

The results of the pilot study were that all the questionnaires proved to be easy to complete and suitable for the intended purpose of the research. The semi-structured questionnaire required some minor adjustments to elicit responses based on the comments made by the subjects which had been sorted into the five approximate categories or groupings. The semi-structured questionnaire was developed around these five categories and proved after these minor adjustments to be a successful tool in ascertaining the information relevant to this study.
INSTRUMENTS

Ways of Coping Checklist (WOC) by Lazarus & Folkman (1984)

(Appendix 2)

This questionnaire addresses the way in which individuals cope with their lives and is based on problem and emotion-focused coping. In its current form the WOC provides a stress and coping paradigm that requires the respondent to focus on a particular stressor in their lives. The results of the WOC fall into two derived scales of problem and emotion-focused coping. The WOC was revised by Vitaliano, Russo, Carr, Maiuro & Becker (1985) the scales being devolved into five separate scales: problem-focused (PF- “made a plan of action and followed it”) and emotion-focused scales as follows: seeks social support (SSS- “talked to others and accepted their sympathy”); Blamed self (BF-“felt responsible for the problem”); wishful thinking (WT- “wished you could change the situation”) and avoidance (A- “refused to believe it had happened). This further break down of the emotion-focused responses derives more from the data collected, highlighting various aspects of emotion-focused coping. It has been used in this revised format in both clinical settings as a useful tool in the individual assessment of coping and also in research.

The questionnaire consists of a 67-item questionnaire that has a 4-point rating scale of coping categories or strategies ranging from “not used at all” to “used a great deal”. Reliability was established by Vitaliano et al (1985) who reported that the revised scales were more consistently reliable than the problem and emotion-focused scales devised by the original authors. Validity and internal consistency was also established from the revisions by Vitaliano et al who reported that depression and anxiety could be shown to be positively related to some aspects of the WOC. The merits of using the revised scales of the WOC has been demonstrated by comparing the internal consistency coefficients and scale inter-correlation’s of the original versus the revised format of the WOC. Vitaliano et al (1985) examined the internal consistency reliability’s and scale inter-correlation’s reporting a revised alpha coefficient ranging
from 0.73 to 0.88. Clearly, this is an important measure of coping that is suited to the design of the present study.

**Impact of Events Scale (IES)** by Horowitz, Wilner & Alvarez (1979)

(Appendix 3)

This measure was devised to assess the emotional sequelae of extreme stress. The IES measures two central components of Post Traumatic Stress Disorder (PTSD). These components of “Intrusion” and “Avoidance” are salient features of PTSD and the impact of any specific traumatic event is assessed by measuring these components using the IES.

The IES consists of a 15-item scale classifying post traumatic stress into two major categories, intrusive thoughts and images and avoidance behaviour. Intrusion describes the penetration of thoughts, cognition's, feelings, mental images and dreams that can occur post trauma. It also refers to the various repetitive behaviours that individuals report as being distressing following trauma. Avoidance refers to the sensation of psychic numbing, conscious denial of consequences and meanings, inhibition of an individual's behaviour and behaviour engaged in to counter phobic tendencies directly related to the stressful life event experienced. The attributes of avoidance and intrusion are not considered as constant but rather as alternating phases or series of phases that occur following the trauma experienced. In the initial phase intrusion is apparent that is then followed by denial. The pattern may then fluctuate until the individual reaches a psychological point of resolution and acceptance. The questionnaire addresses this by describing various emotional reactions, scoring is indicated on a 4-point scale ranging from “not at all” to “often”.

Horowitz et al (1979) and Horowitz (1990) showed that this instrument was a valid and reliable measure with good test-re-test and internal consistency reliability. These authors showed that the test was psychometrically sound and that the two-factor structure was a valid measure of avoidance and intrusion. The sensitivity of the
measure has been noted by Schwarzwald, Solomon & Weisenberg (1987) with combat trauma. The IES has been validated by many other authors, most recently by Robbins & Hunt (1994) who report a Cronbach alpha for the intrusion scale at 0.86 with avoidance at 0.64. The evidence presented shows that IES is a useful instrument for assessing the impact of trauma across a wide and varied range of populations. Thus, this informs our choice regarding a suitable measure for the present study.

The State-Trait Anxiety Questionnaire (STAI) by Spielberger, Gorsuch, Lushene, Vagg & Jacobs (1970)

(Appendix 4)

This 40 item Inventory has been widely used in research and clinical practise and compares well with other anxiety measures. The Inventory measures two distinct concepts of anxiety: State Anxiety (A-State) and Trait Anxiety (A-Trait).

The A-State scale (20 items) evaluates such feelings as tension, nervousness, worry and apprehension that may fluctuate over time. The A-Trait scale (20 items) evaluates the more stable personal qualities, characteristics and differences in terms of individual disposition to anxiety. Therefore, the differences between state and trait anxiety can be compared with each other, thus revealing an individual pattern of how anxious a person is generally (A-Trait) compared to their current state of anxiety (A-State). It is generally regarded that having a high score of Trait anxiety will give rise to higher levels of State anxiety because of an underlying personal disposition.

Reliability of the STAI has been reported in the extensive research that has used this measure. In most applications the STAI has been interpreted as a uni-dimensional measure of state and trait anxiety (Spielberger & Vagg, 1984). The validity of the measure has been tested over many populations including psychiatric and medical disorders with additional normative data available over several populations including general medical and surgical patients (Spielberger & Vagg, 1984). The internal consistency is established using the overall median alpha coefficients: State Anxiety
0.92, Trait Anxiety 0.90. It has also been translated into other languages without losing its properties (Hanin & Spielberger, 1983). Furthermore, Spielberger (1985) discussed the validation and reliability of the STAI drawing attention to the diversity of populations over which it has been tested reliably. Thus, the Inventory provides a measure that is reliable, comparable to similar instruments for anxiety and validated over many studies, thereby warranting inclusion in the present study.

**Beck Depression Inventory (BDI)** by Beck & Steer (1979)

(Appendix 5)

The BDI is a 21-item instrument designed to assess severity of depression. Over many years it has become widely accepted in clinical practise and research as a valuable instrument for measuring severity of depression.

The BDI provides an effective and efficient tool for research because of the ease of completion by the patient and the simplicity of the scoring mechanism (Beck & Steer, 1979). Each of the 21-items are rated on a 4 point scale ranging from 0-3. There is a maximum score of 63. Scores from 0-9 are considered within the normal range, scores of 19-29 indicate a moderate to severe rate of depression with scores of 30 and over indicating an extremely severe depressive state.

The measure has been employed effectively across many settings and with normal, psychiatric and medical populations. The reliability and validity of the instrument has been well documented by Beck, Steer & Garbin (1988), despite the number of refinements to the definition of depression it still effectively assesses the severity of depression. The psychometric properties of the BDI have been extensively reported by the original authors showing the high internal consistency of the measure in both clinical and non-clinical populations (Beck & Steer, 1979). Using Cronbach’s coefficient alpha across a variety of populations the results ranged from 0.79 to 0.90. Beck, Steer & Garbin (1988) reviewed previous research that had used the BDI between 1961 to 1986 concentrating on validating the psychometric properties of this
measure. They reported a mean alpha coefficient of 0.81 with non-psychiatric respondents and high levels of concurrent validities. Further support for the reliability, internal consistency and validity of this measure across many populations has been reported from numerous sources (Rapp, Parisai, Walsh & Wallace 1988, Levin, Llabre & Viner 1988, Kashani, Sherman, Parker & Reid 1990, Novy, Nelson, Goodwin & Rwzee 1993, Byrne & Baron 1994). Because of the qualities of reliability and validity expressed in this measure of depression, this supports the choice of instrument in the present study.

Eysenck Personality Inventory (EPI) by Eysenck & Eysenck (1964)

(Appendix 6)

The EPI was developed to measure two dimensions of personality that of extroversion and neuroticism. This Inventory has been widely used and it has many applications including research purposes in psychiatry and medicine, individual testing, research in normal populations and in market research.

The EPI consists of 57 questions relating to the way a respondent behaves, feels, and acts. The instrument is designed to draw out the personal attributes of extroversion (24 items) and neurotisism (24 items). A typical extrovert may be described as sociable, optimistic, carefree, easygoing, having a tendency for aggression and unreliability. Whereas, a typical introvert is described as quiet, retiring, reserved, reliable, pessimistic and is rarely aggressive. Included in the EPI is an 9-item Lie Scale that may be used to eliminate respondents demonstrating “desirability response set”. Based on previous work by the same authors (Eysenck & Eysenck, 1959b) the Lie Scale has been shown to be a reliable and valid scale that can detect individuals who are “faking good”. In general, a score of 10 or above on the Lie Scale indicates that the scores for neurotisism and extroversion should be viewed with scepticism.
The reliability of the scales has been reported with test-re-test and consistency reliability (Eysenck & Eysenck, 1964). The test-re-test reliabilities are reported as 0.84 and 0.94. The split-half reliabilities using the Spearman-Brown formula range from 0.85 to 0.95 and for the individual scales they range from 0.74 to 0.91. Therefore, direct evidence has been given regarding the validity of the instrument as a descriptive tool for personality (Eysenck & Eysenck, 1964). This has been supported by more recent studies demonstrating the test reliability of this measure across different cultures and populations (Balkisson, 1988, Wilson & Doolabh, 1992), thus giving indication of its usefulness in the present study.

The Golumbok Rust Inventory of Marital State (GRIMS) Questionnaire by Rust, Bennum, Crowe & Golombok (1986).

(Appendix 7)

This instrument assesses the overall quality of a relationship between a man and a woman who are cohabiting or married to each other. It does not show the quality of the sexual relationship but attempts to reflect the satisfaction with the relationship generally.

The GRIMS questionnaire seeks to highlight areas of difficulty in a marital relationship, with an emphasis on communication, shared interests, trust, respect, and general levels of satisfaction with the relationship. The qualities it seeks to highlight are included in the 28-item scale and these are rated on a four point scale from "strongly disagree" to "strongly agree".

Reliability of the test has been established by the original authors indicating a strong degree of internal consistency. Two internal consistency methods were used, split-half and alpha coefficients with a high degree of internal consistency within the GRIMS items, coefficients ranged from 0.81-0.94 (Rust et al, 1986). Validity and reliability have been demonstrated by the use of both diagnostic and empirical research methods (Rust, Bennum, Crowe & Golombok, 1990). These authors showed that significant
agreement between therapists ratings and GRIMS scores and by the administration of
the GRIMS to couples undergoing marital therapy could be achieved. The GRIMS
scores obtained were shown to be reduced following therapeutic intervention and
correlated highly with the therapist's ratings of change. The work of Collier (1989)
confirmed the usefulness of this measure in diagnosis of marital problems with British
respondents. This Inventory therefore offers an excellent indication of severity of
problems in a marital relationship that is useful for the purposes of the present study.

Rosenberg Self-Esteem Scale (RSE) by Rosenberg (1965)

(Appendix 8)

This scale is a measure of global self-esteem that has its place both in research and
clinical practise. It provides a useful measure of self-esteem in individuals and has been
widely used with many sample populations.

The RSE is a 10-item measure of self-esteem that has both positive and negative items.
Five of the items are phrased positively and the other five are phrased negatively. This
is to reduce the possibility of an acquiescent response set. To help to control for this
the negatively phrased items are scored in reverse. The RSE is scored using a Likert
scoring method, scores ranging from 1-40.

The reliability, internal consistency, stability and validity of this measure have been
obtained via research into a normal population of adolescents in a large scale study
(Rosenberg, 1965). The normative data for the study being randomly chosen from a
sub-sample of one-third of the sample population. Further validation of this measure
has been conducted with other populations and cultures (George & Bearon, 1980,
the test internal consistency and reliability of the measure stating a coefficient of 0.85.
These authors compared the validity of the RSE with other self esteem measures, they
reported coefficients ranging from 0.56 to 0.83. On this basis the RSE proves to be an
adequate measure of global self-esteem that warrants inclusion in the present study.
General Health Questionnaire (GHQ-12) by Goldberg & Williams (1988)

(Appendix 9)

The 12 item GHQ is a widely used questionnaire that encompasses a wide range of items indicative of psychological distress and is a frequency count of the symptoms of distress. There are several versions available, the shortest version being used in this study (GHQ-12). The GHQ provides a dimensional measure of the symptomology of psychological distress based on items in the questionnaire being both health and illness related.

The questionnaire is very simple to complete and score. The recommended scoring method is by use of the Likert Scale creating a possible score range of 12-48, the higher the recorded score the higher the level of distress present.

The GHQ has good test and re-test validity, evidence is given by Goldberg & Williams (1988) of the GHQ’s sensitivity to change in the symptomology of psychological distress in respondents over time. The norms for the GHQ vary dependant upon the scoring method used, with the norms for the GHQ-12 (Likert scoring) having been consistent over time (Milne, 1987). The GHQ-12 has increased in popularity over recent times, it has become a widely used and reliable tool with many studies of its validity. The internal consistency of the GHQ is reported by Banks, Clegg, Jackson, Kemp, Stafford & Wall (1980) using Cronbach’s Alpha Coefficient, this was exceptionally high with a range between 0.82-0.90. This widely used measure has been successfully compared with previous versions (Vieweg & Hedlund, 1983). The GHQ-12 has proved itself a useful measure demonstrating it’s properties across many cultures reported in studies such as Picconelli, Bisoffi, Bonn & Cunico (1993). The reliability and validity of the 12-item GHQ has been more recently been supported by Politi, Piccinenni & Wilkinson (1994). Therefore, the validity and reliability of the GHQ-12 as an effective frequency measure of the symptoms of psychological distress warrants it’s inclusion in the present study.
The Semi-Structured Interview Schedule

(Appendix 10)

The semi-structured interview schedule was developed from the pilot phase of the study. It was devised with the intention of facilitating the interviews in the main study. This was a particularly useful way of collecting relevant data as no known questionnaires exist that are specifically aimed at eliciting these kind of responses in women following mastectomy and lumpectomy surgery.

A semi-structured approach was chosen because un-structured approaches often lead to a lack of objectivity owing to the need to establish a rapport with the respondent under interview (Glesne & Peskin, 1992). These authors point out that although providing a greater breadth of the problems for review by the use of an open-ended approach, there are problems with maintaining objectivity. On the other hand, a more formal structured interview approach would not uncover the full extent and breadth of the issues under investigation (Denzin, 1989). This is because studies using this approach require that the interviewer does not enter into any discussion, offer an opinion or reply to questions posed by the respondent (Glesne & Peskin, 1992). This keeps unnecessary information to a minimum (Field & Morse, 1985) as a consequence the information gathered in structured interviews may cover a very narrow area. It was on this evidence that a semi-structured approach to information gathering was considered appropriate for this study.

The general approach to the interview schedule was one of exploration of the issues revolving around body image difficulties and problems experienced in this respect since the operation. Probe questions have been used to facilitate the extent, breadth and nature of the reported problems.

The following are examples of the kind of probe questions used.
Questions Probes

<table>
<thead>
<tr>
<th>Has your husband or partner seen your scar?</th>
<th>(If not) why not?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any problems with clothes or underwear fittings?</td>
<td>(If so) what are they?</td>
</tr>
<tr>
<td>Do you continue to be upset?</td>
<td>If so, what is it that upsets you?</td>
</tr>
<tr>
<td>Do you feel the operation has affected your sense of being feminine?</td>
<td>If so, how?</td>
</tr>
</tbody>
</table>

Questions were also raised concerning the time of diagnosis, radiotherapy treatment and continued support since that time. The emphasis lay on the extraction of relevant statements that would be helpful in shaping mental health, physical and voluntary services and how they could be improved.

An example of what constituted a relevant and non-relevant statement needs further explanation. A non-relevant statement would be best described as one made in a general sense about their appearance or self:

“ I have always considered my body unattractive........”

or

“My breasts were always my best feature before this happened....”

A relevant statement would be best described as being directly related to the breast surgery and it’s consequences, for example:

“I’ve had to get rid of all my low cut dresses and blouses because of the scarring...”

or
“It’s a big deformity because I’m full-breasted on one side only now...”

The relevant statements that formulated the categories were recorded in the main study using the memo and note-taking method (Strauss and Corbin, 1990).

**Data Analysis**

The semi-structured interviews were analysed using sentences as the unit of analysis. In order to categorise and code the statements, each relevant sentence was extracted from the text and recorded on an individual card with a corresponding patient identification number. This followed the memo and note taking method described by Strauss and Corbin (1990). The individual cards were sorted and coded into groups of similar statements by the researcher. For example, all statements made concerning the wearing of a prosthesis were placed together. These coded statements were then reviewed by the researcher to further evaluate their content, in this way the categories were refined. The assumption has been made that the greater the number of negative body image statements recorded, the more likely that this is indicative of distress regarding body image issues. In order to control for bias a sample of the analysis was reviewed by an independent researcher and inter-rater reliability was established.
RESULTS

Because of the diversity of the approach used, this study has gained in terms of both quantitative and qualitative perspectives. The results of the quantitative data collected by the use of standardised questionnaires will be presented followed by the qualitative analysis of the interviews conducted. It is hoped that this will clarify what each perspective has contributed to the research whilst not detracting from the combined nature of the multi-methodological approach.

Characteristics of the Sample

Of the 40 respondents that took part in this study 20 had undergone mastectomy and 20 had lumpectomy surgery. The mean age of the respondents overall was 51 years with a Standard Deviation (SD) of 9.16. The respondents in the mastectomy group had a mean age of 49.5 years (SD = 9.30), whereas, the lumpectomy group had a higher mean age of 53.1 years (SD = 8.84). There was no significant difference between the two groups in terms of age (t = -1.25, p > 0.218).

The mean age of the respondents at the time they underwent surgery was 45.3 years (SD = 9.0). At the time of their operation the mastectomy respondents had a mean age of 43.0 years (SD = 10.1) and the lumpectomy group had a mean age of 47.5 years (SD = 7.4). The age at time of surgery ranged from 26 to 62 years. There was no significant differences between the two groups in terms of age at the time of surgery (t = -1.61, p > 0.114). The Mean age from time of surgery was 6.03 years (SD = 9.0). The Mean age from the time of surgery for the mastectomy group was 6.75 years (SD = 8.5) with the lumpectomy group having a Mean score of 5.06 years (SD = 9.0).

Of those in a relationship at the time of interview 27 were married, 6 were living with a partner, 3 were divorced and 4 were widowed. A comparison between the groups was conducted to highlight any changes in marital status since the operation. This was carried out using a Chi-square test (Chi-square = 0.678, p < 0.87). There were no significant differences between the two groups in terms of a change in marital status post-operatively.
The Internal Consistency and Reliability of the Measures used

Each of the tests used were checked for their reliability and internal consistency with the present sample population. Overall, with the exception of the BDI, the WOC sub-scale of seeking social support and the two EPI sub-scales of neurotisism and lie, the reliability of the tests used, was consistent with the work of validation studies previously discussed.

The results include the means and standard deviations (SD) of each instrument and sub-scale. The reliability levels of the instruments are reported using Cronbachs Alpha Coefficient and Split-half reliability's where appropriate.

The Ways of Coping Inventory

The means and standard deviations (SD) and the number of items in each of the sub-scales of the Ways of Coping Inventory are given as follows:

Table 1a: Means and Standard Deviations -Ways of Coping Inventory

<table>
<thead>
<tr>
<th>SUB-SCALES</th>
<th>Mean</th>
<th>SD</th>
<th>No of Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused (PF)</td>
<td>11.7</td>
<td>5.4</td>
<td>15</td>
</tr>
<tr>
<td>Seeks Social Support (SSS)</td>
<td>3.9</td>
<td>2.6</td>
<td>6</td>
</tr>
<tr>
<td>Blames Self (BS)</td>
<td>2.6</td>
<td>2.4</td>
<td>3</td>
</tr>
<tr>
<td>Avoidance (A)</td>
<td>9.5</td>
<td>4.2</td>
<td>8</td>
</tr>
<tr>
<td>Wishful Thinking (WT)</td>
<td>8.9</td>
<td>4.5</td>
<td>10</td>
</tr>
</tbody>
</table>

Vitaliano et al (1985) quote the Means and SD for spouses of patients with Alzheimers disease. Their results are closest to the present population for the purposes of comparison, and are as follows: Problem Focused (Mean = 20.71, SD = 9.51); Seeks Social Support (Mean = 8.65, SD = 4.80); Blames Self (Mean = 2.07, SD =2.44); Avoidance (Mean = 8.53, SD = 5.23); Wishful Thinking (Mean = 9.36, SD = 5.89). There are no implications that individuals cope better with a higher or lower score on the WOC, rather that they are
using one of way coping more than another and this needs to be borne in mind when interpreting the results. The present population have obtained similar results on most aspects of the WOC, however, there are differences between the results on the Problem Focused and Seeks Social Support scales.

The coefficients for the Ways of Coping sub-scales appear in the table below:

Table 1b: Sub-scale Coefficients - Ways of Coping Inventory

<table>
<thead>
<tr>
<th>SUB-SCALES</th>
<th>Cronbachs Alpha Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused (PF)</td>
<td>0.73</td>
</tr>
<tr>
<td>Seeks Social Support (SSS)</td>
<td>0.58</td>
</tr>
<tr>
<td>Blamed Self (BS)</td>
<td>0.80</td>
</tr>
<tr>
<td>Wishful Thinking (WT)</td>
<td>0.80</td>
</tr>
<tr>
<td>Avoidance (A)</td>
<td>0.69</td>
</tr>
</tbody>
</table>

The measure proved to have acceptable coefficient values on all but one of the sub-scales. It can be said to be reliable and valid with the current sample in all aspects, apart from the sub-scale of seeking social support, this sub-scale has a low level of reliability (0.58) with the test population. This sub-scale (SSS) cannot therefore be considered a reliable measure with this test population. All other sub-scales can be reported as acceptable instruments with in the present study.

The Impact of Events Scale

The IES measures two cognitive components of traumatic experience commonly found in Post Traumatic Stress Syndrome, namely, avoidance and intrusion. A total score of 15 and above on this scale indicates mild distress with scores of 30 and above indicating marked distress. The means and SD for this measure and the number of items in the sub-scales are reported in the table below:
Table 2: Means and Standard Deviations - Impact of Events Scale

<table>
<thead>
<tr>
<th>SUB-SCALE</th>
<th>Mean</th>
<th>SD</th>
<th>No of Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrusion</td>
<td>6.15</td>
<td>3.9</td>
<td>5</td>
</tr>
<tr>
<td>Avoidance</td>
<td>7.13</td>
<td>3.7</td>
<td>5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>13.30</td>
<td>5.6</td>
<td>10</td>
</tr>
</tbody>
</table>

Of the whole sample 30% (n = 12) of the scores were above the cut off point indicating a very low level of mild distress.

The overall coefficient for the Impact of Event Scale was 0.89. The Intrusion sub-scale was 0.74 with Avoidance at 0.83. This measure therefore has value as a reliable tool with the test population.

The State Trait Anxiety Inventory

The means, standard deviations and number of items for each sub-scale are reported below:

Table 3a: Means and Standard Deviations - State Trait Anxiety Inventory

<table>
<thead>
<tr>
<th>SUB-SCALE</th>
<th>Mean</th>
<th>SD</th>
<th>No of Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Anxiety</td>
<td>34.4</td>
<td>12.4</td>
<td>20</td>
</tr>
<tr>
<td>Trait Anxiety</td>
<td>39.3</td>
<td>10.0</td>
<td>20</td>
</tr>
</tbody>
</table>

The scores on the STAI can vary from a minimum of 20 to a maximum of 80. The average norms for adult females are a Mean of 35.20, SD 10.61 for State Anxiety and a Mean of 34.79, SD 9.22 for Trait Anxiety (Spielberger et al, 1970). Therefore, the present sample score slightly higher with respect to Trait Anxiety than the average female and slightly lower than the average female for State Anxiety.
The measure proved to be useful with this population having coefficients as follows:

Table 3b: Sub-scale Coefficients - State Trait Anxiety Inventory

<table>
<thead>
<tr>
<th>SUB-SCALES</th>
<th>Cronbachs Alpha Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
<td>0.93</td>
</tr>
<tr>
<td>Trait</td>
<td>0.73</td>
</tr>
</tbody>
</table>

This informs the present study regarding the acceptable value of this test with the current test population.

The Beck Depression Inventory

This 21 item measure proved to have a very low level of internal consistency and reliability with this sample population (Mean = 9.4, SD = 9.77). As the cut off point for mild depression is a score of 9, this sample cannot be considered depressed. The coefficient was very low at 0.21, consequently this measure may not be regarded as a helpful or useful measure with the test population of respondents and puts in doubt any results obtained from this questionnaire. Therefore, the scale cannot be calculated because of it’s low reliability.

The Eysenck Personality Inventory

The means, standard deviations and number of items in each sub-scale appear in the table below:

Table 4a: Means and Standard Deviations - Eysenck Personality Inventory

<table>
<thead>
<tr>
<th>SUB-SCALE</th>
<th>Mean</th>
<th>SD</th>
<th>No of Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurotisim</td>
<td>11.7</td>
<td>6.9</td>
<td>24</td>
</tr>
<tr>
<td>Extroversion</td>
<td>6.8</td>
<td>3.2</td>
<td>24</td>
</tr>
<tr>
<td>Lie</td>
<td>2.0</td>
<td>1.2</td>
<td>9</td>
</tr>
</tbody>
</table>
Comparing the test population with the normal population (Eysenck & Eysenck, 1964: Normal Population - Neurotism Mean = 26.22, SD = 7.77, Extraversion Mean = 19.58, SD = 9.03 which are much higher values than in the reported population. The lie scale has a cut off point of 10 that shows ‘faking good’, as this population has a low score of 2 on the Lie Scale they cannot be said to be ‘faking good’ their results.

The EPI indicated reliability levels well below what is acceptable on the Lie (0.21) and Neurotism (0.15) scales. The usefulness of these two scales with the test population is therefore in doubt.

This test was examined using Split-half analyses rather than Cronbachs Alpha following the statistical format used by the authors in the EPI manual (Eysenck & Eysenck, 1964), the results are as follows:

Table 4b: Sub-Scale Split-Half Reliability’s - Eysenck Personality Inventory

<table>
<thead>
<tr>
<th>Sub-Scales</th>
<th>Split-Half Reliabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lie</td>
<td>0.21</td>
</tr>
<tr>
<td>Neurotism</td>
<td>0.15</td>
</tr>
<tr>
<td>Extroversion</td>
<td>0.68</td>
</tr>
</tbody>
</table>

The results of the analysis using the sub-scales of Lie (0.21) and Neurotism (0.15) cannot be calculated resulting in a low level of reliability with this test population. Although the results of the Extroversion scale may be considered reliable with a coefficient of 0.68. However, as two of the three sub-scales cannot be calculated, the EPI can only be said to be reliable with respect to the Extroversion scale with this test population.
The Golombok Rust Inventory of Marital Satisfaction

The 28 item GRIMS has been shown to be reliable with the sample population having a mean of 30.2, SD of 14.7, the raw score cut off point for the GRIMS indicated that scores of 30-33 are within the average range for marital satisfaction. A reliability coefficient level of 0.87 can be reported, therefore, this test has an acceptable coefficient value in terms of reliability with the current population.

The Rosenberg Self Esteem Inventory

The 10 item RSE is scored from 1-40 with a low-to-high ranking for positive items and the opposite for negative items. High scores indicate a high level of self-esteem with a very low level of self-esteem reflected in the low scores of this population on this measure. A comparison of the means and SD can be made with a small sample of older adults (Stevens-Ratchford, 1992). This author reported a mean of 32.67, SD 3.9 that is much higher than in the present population. The RSE result used with the test population had a mean of 1.9, SD of 1.96. On closer examination of the data little variance can be reported between the respondents with a minimum raw score of 0 and a maximum score of 6 being reported. Of the sample sixteen respondents scored 0 and ten respondents scored 1 which may explain the very low mean of 1.9 with the present population. However, a reliability coefficient of 0.67 can be reported. This informs the present study with regard to a satisfactory level of reliability with the present study.

The General Health Questionnaire

The GHQ used in this study was the 12 item version. The mean score was 21.5 with a SD of 12.5, a score of 5 and above on the GHQ meeting the criteria for psychiatric caseness. This population may therefore said to be fulfilling the criteria for psychiatric caseness on this frequency measure for symptoms of general mental health. The overall coefficient was 0.91 using the GHQ - 12 with the present sample. Therefore, these may be regarded as acceptable values informing on the excellent reliability of the test in the present study.
It was hypothesised that mastectomised respondents would have higher scores than respondents having had a lumpectomy on the following variables: IES, GHQ, RSE, and the Ways of Coping Inventory

Comparisons were made between respondents who had experienced mastectomy versus lumpectomy using unrelated t-tests. All t-tests, throughout the results were reported respondent to the critical values of the Bonferroni Multiple Comparison Test. A list of the variables are contained in Appendix 11.

A number of other measures such as the Impact of Events Scale (IES), the State-Trait Anxiety Inventory (STAI) and the Rosenberg Self Esteem Inventory (RSE) failed to show any significant differences between the two groups.

The results achieved significance between the groups on the GHQ measure ($t = 3.03, p < 0.05$). On further examination the mastectomy Ss showed greater levels of psychiatric caseness on this measure ($\text{Mean} = 26.9, \text{SD} = 14.01$) than the lumpectomy group ($\text{Mean} = 16.05, \text{SD} = 7.69$).

No significant differences could be found on most aspects of the Ways of Coping Inventory. The two test groups score similarly with respect to the Problem Focused (PF) sub-scale with no significant difference reported.
The hypothesis cannot be supported with respect to most of the variables under investigation as no significant differences between the groups could be found on the IES, RSE or Ways of Coping measures. Although, the very low levels of self esteem in both groups are of note. However, there is a significant difference between the groups regarding levels of psychiatric caseness as indicated on the GHQ. The mastectomised group are considered to fit the criteria for psychiatric caseness more so than the lumpectomised group, therefore, the hypothesis can be upheld with respect to the GHQ measure.

It was hypothesised that maladaptive emotion-focused styles of coping as measured by the Ways of Coping Inventory would be significantly higher in mastectomised respondents than those having had a lumpectomy.

No differences were reported between the two groups on the emotion-focused sub-scales of Avoidance or the Wishful Thinking using the Ways of Coping Inventory. Interestingly, only one of the sub-scales of the Ways of Coping Inventory indicated any significant difference. The sub-scale Blaming Self (BF) showed a significant difference between the mastectomy Ss and the lumpectomy Ss, with the lumpectomy group having higher scores. The significant difference found in the sub-scale Blamed Self (t = -4.20 p < 0.01) indicated that the lumpectomy Ss are more likely to blame themselves for their illness than the mastectomy Ss.
It was hypothesised that the number of negative verbal statements reported about negative aspects of body image would be greater for respondents who had undergone mastectomy compared to those who had undergone lumpectomy.

To provide a guide to what may formulate problems related to body image in these respondents, the negative body image responses respondents made during the course of the interview held with the Researcher were recorded (full details have been given in the Method as to how this was achieved).

Each of the statements were counted, scoring was on a 1-point system, 1 point being allocated for each negative statement recorded. A random selection of the responses were also categorised by the Research Assistant (this has also previously been described). Inter-rater reliability was assessed using a random selection of the interview transcripts. Reliability was established using Cohen’s K measurement of reliability, a high level of consistency was found between the Researcher and the Research Assistant for the total number of statements revolving around negative body image issues (K= 0.88).

Furthermore, the sub-categories identified within the theme or category of body image were also assessed for inter-rater reliability again using a Cohen’s K measurement of reliability. A high level of agreement was obtained for each sub-category using a random sample of recorded statements extracted from the transcripts of the interviews. Reliability was established, the sub-categories and their relevant Cohen’s K reliability’s are tabulated in Table 3 below.
Table 3: Issues relating to negative body image - Sub-Category Reliability

<table>
<thead>
<tr>
<th>SUB-CATEGORY</th>
<th>COHEN's K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems with Physical Appearance</td>
<td>1.0</td>
</tr>
<tr>
<td>Problems with Prosthesis</td>
<td>1.0</td>
</tr>
<tr>
<td>Grief over the loss of the breast</td>
<td>0.84</td>
</tr>
<tr>
<td>Negative Responses by Partner</td>
<td>0.88</td>
</tr>
<tr>
<td>Loss of Femininity problems</td>
<td>0.84</td>
</tr>
</tbody>
</table>

The total number of statements made were compared between the two groups and analysed using a Mann Whitney test. The results are as follows:

Table 4: A comparison of the number of body image statements between the two groups

<table>
<thead>
<tr>
<th>Type of Surgery</th>
<th>Number of Respondents</th>
<th>Rank Sum</th>
<th>u = 3.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mastectomy</td>
<td>20</td>
<td>606.5</td>
<td></td>
</tr>
<tr>
<td>Lumpectomy</td>
<td>20</td>
<td>213.5</td>
<td></td>
</tr>
</tbody>
</table>

Z adjusted = -5.33 p = < 0.000

Type of surgery proved to have a significant impact on the number of statements made about negative body image issues. The mastectomised group reported a much higher
numbers of statements (Mean Score = 15.0, SD = 2.62) than the lumpectomised group (Mean Score = 6.55, SD = 2.03).

A comparison was made between the two groups regarding the number of negative body image statements each group made. The sub-categories of issues revolving around negative body image are also reported; these differences are demonstrated in the table below:

Table 5: A Comparison of statements relating to negative body image

<table>
<thead>
<tr>
<th>Sub-categories</th>
<th>Mastectomy Group Scores</th>
<th>Lumpectomy Group Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Appearance</td>
<td>82</td>
<td>61</td>
</tr>
<tr>
<td>Problems with Prosthesis</td>
<td>64</td>
<td>0</td>
</tr>
<tr>
<td>Grief concerning loss breast</td>
<td>54</td>
<td>18</td>
</tr>
<tr>
<td>Loss of Femininity</td>
<td>63</td>
<td>22</td>
</tr>
<tr>
<td>Negative Partner Responses</td>
<td>35</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total Score</strong></td>
<td><strong>298</strong></td>
<td><strong>123</strong></td>
</tr>
</tbody>
</table>

The sub-category of problems with the prosthesis related only to the mastectomised group with an overall statement score of 64 points. The sub-category of negative partner responses totalled 57 statements, this was constituted from the 17 mastectomised women and 14 lumpectomised women who were married or in relationships.

From the results it is clear that Ss having had a mastectomy did report more negative body image statements than Ss having had a lumpectomy. A further comparison can be made by
extracting out the number of responses made by the mastectomy group concerning problems with their prosthesis \((n=64)\). The Total score for the mastectomy group is then reduced to 234 statements, nonetheless, this is still almost double the statements made by the lumpectomy group. Therefore this hypothesis has been upheld.

It was hypothesised that higher levels of maladaptive, emotion-focused styles of coping will be significantly related to greater negative body image statements, GHQ scores, IES scores and STAI scores.

The analysis was carried out, combining both tests groups \((n=40)\), using a Spearmans correlation. One significant relationship between maladaptive, emotion-focused styles of coping and the variables tested is reported. Scores on the Ways of Coping sub-scale Blamed Self (BS) were found to be correlated with higher levels of total negative body image statements \((Rho = -0.471, p = < 0.002)\).

The results show a clear relationship between one aspect of maladaptive coping style (Blamed Self) and Total negative body image statements.

It was hypothesised that women in a stable relationship would have lower scores on dependent variables such as IES, and State Anxiety scores.

Firstly, the impact of marital status was examined using a MANCOVA with marital status as the independent variable, Total body image statement score as the covariate and GHQ
scores, IES-Intrusion, IES-Avoidance and State Anxiety as the dependent variables. Of the 40 Ss 31 were in stable or married relationships.

There was no significant impact on any of the dependent variables (Wilk's lambda 0.84, p < 0.336). Therefore, the respondents showed no differences in their levels of psychiatric caseness as measured by the GHQ, the impact traumatic of the event and current anxiety state whether they were married, single widowed or divorced.

Reported levels of marital satisfaction were examined. The mastectomy group were compared with the lumpectomy group, this was to investigate any differences in reported marital satisfaction between the two groups. Within the groups, 17 married or cohabiting respondents had undergone surgery for mastectomy, married and cohabiting respondents numbered 14 in the lumpectomy group. A comparison of these respondents who were in relationships was made using the Golombok-Rust Inventory of Marital Satisfaction (GRIMS). Using unrelated t-tests failed to find any significant differences (t = -0.784, p < 0.43) in reported levels of marital satisfaction between those respondents having had a mastectomy compared to those having had a lumpectomy.

The relationships between the variables were explored:

The intercorrelations between the variables were explored using a Pearson Correlation and where appropriate, Spearman's Rho was also used. Unless otherwise stated the intercorrelation's are Pearson's r. A full summary of all intercorrelation's are contained in Appendix 13 (Tables A, B and C). The following significant results, reported here, formulated additional hypotheses raised from the analysis of the data and highlight some interesting aspects that emerged from the data.
Age was investigated to see if the impact of the operation was greater in younger respondents.

Age was related to IES Total scores with which it was negatively correlated ($r = -0.31$, $p < 0.04$). Therefore, the results indicate that younger women are more traumatised by the impact of breast surgery than older women in this test population.

Age was compared with styles of coping to reveal any differences in the way younger respondents cope compared to older respondent.

Age was not related to coping style with the Ways of Coping Inventory with the exception of the Self Blame sub-scale ($r = 0.31$, $p < 0.05$). There were, however, significant relationships between the sub-scales of the Ways of Coping Inventory (Appendix 13, Table 4). The results reflect significant relationships between the sub-scales of the Ways of Coping Inventory.

The relationship between negative statements about body image and the GHQ was investigated.

The total number of negative statements concerning body image, for each respondent was significantly related to the GHQ ($Rho = 0.413$, $p< 0.008$). Therefore, those respondents that scored highly on the GHQ indicating psychiatric caseness also reported a higher number of negative body image statements.

Some expected relationships between the variables.

Some of the variables would be expected to be correlated with each other because of their close relationship and overlapping nature of the tests. One would have expected the GHQ
and the IES to be significantly correlated for this reason. Furthermore, it would be expected that the WOC would be significantly correlated to the IES. However, it was found that only two of the variables were significantly related to one another, the IES Total scores being significantly correlated with GHQ scores ($r = 0.32, p < 0.04$). The other variables tested were not significantly correlated with one another which was an unexpected finding as these tests usually bear a close relationship to one another.

**The qualitative research question addressed by this study has centred upon breast surgery as a major life stressor.** Particular attention has been paid to the problems revolving around having a compromised body image and to a lesser extent concerns about diagnosis, radiotherapy and sources of continued support.

The results are reported under the headings of the sub-categories to emerge from the qualitative analysis of the semi-structured interviews. The assumption has been made that the higher the number of negative statements made the greater distress around body image issues. For clarity the quotes are presented with the patient code and identification number, M1 - M20 representing the respondents from the mastectomy group and L1 - L20 for the lumpectomy group.

**Physical Appearance**
All of the respondents that had undergone mastectomy reported their distress about their physical appearance. They told of how glad they were to be alive, whilst at the same time voicing their concern and distress regarding the extent of the scarring endured.

M2 "I cried when I first saw the terrible scar, I know it was for my own good, after all I am alive, but the scar still bothers me it’s so big, I try to hide it, not look down at it.......I’m sure they could have made a better job of it than they did...you know less of a scar"
Respondents from both groups reported that radiotherapy treatment had lead to further scarring (n= 12), some women (n= 6) felt their scarring was extensive. Regret was also expressed about the need for such a radical operation.

M28 “The radiotherapy made the scarring much worse..”

Older mastectomised women (aged 60 and beyond) were less concerned about their physical appearance (n= 3).

M12 “when you get to our age these things are less important...How you look, that is...”

The younger mastectomied women (under 45 years) expressed considerable anger about their physical appearance since the operation. Although these respondents numbered only 6, they showed more distress than the other respondents and frequently commented on the desire to seek out breast re-construction.

M34 “I cannot, just cannot, tell you how deeply this operation has upset me. The surgeons knife has destroyed my life, I am scarred beyond belief.....(respondent broke down in tears). I am so angry about the way I look now....perhaps they can do something”

M3 “Yes, I am upset by the way I look now, I wish I could have an implant, perhaps I’ll ask if it’s possible.”

Two of the respondents seemed too distressed to consider this option reporting that the scarring was too extensive for them ever to lead a normal life again. When questioned further about this, normal life meant being able to have a full and uninhibited sex life, to join sports clubs and to get changed in a gym or clothes shop.
changing room without fear that someone would see them and make them feel awkward and embarrassed.

Most of the mastectomised group (n= 18) and some of the lumpectomy group (n= 8) found looking at the scar upsetting. They found looking in the mirror, bathing and showering problematic in respect of their scar. Most respondents interviewed reported avoiding looking at or touching their scar (n= 26).

M2 "...even now four years after my surgery I cringe every time I touch it, whether purposefully or accidentally"

Many of the mastectomised group (n= 14) reported that since the operation they locked the bathroom door when dressing or bathing for fear of their husbands seeing their scar, all reported that this behaviour had only begun after the operation. The younger members (under 45 years) from the mastectomy group (n= 6) said that they would no longer sunbathe topless, for fear that their scar would be noticeable.

The problems with prosthetics
As none of the lumpectomy group required a prosthesis the quotes are drawn from the comments of the mastectomised group only.

Some of the respondents (n= 7) had found the prosthesis they had was uncomfortable, especially during the first few months post surgery. A number of respondents (n= 8) expressed extreme anger towards their prosthesis and resented the need to wear it.

M3 “I hate it, I resent having to wear the thing...(respondent raises her voice). I hate it, it really is a disgusting object.”

However, all the women commented upon the sympathetic and sensitive way that their initial and subsequent fittings had been carried out, much credit was given to the advice offered by the Breast Care Nurses involved in the fitting of the prosthesis.
The majority of women reported being satisfied with their prosthesis (n=13). As one woman said

M27 "...you have to form a relationship with it in a strange sort of way otherwise you would want to reject it"

Some respondents found their prosthesis heavy (n=6). Of these women 3 said they often replaced it with the 'Comfie' (a soft padded prosthesis) they were initially given post surgery. This is made of a much softer material and although not as robust as the prosthetic enhanced the outward visible appearance of the breast area during the time of wound healing.

Two women reported that they had sewn soft cushioned material into the breast cup of their nightwear which they said made the loss of the breast less obvious and helped to create a better sense of psychological well-being and sensuality. Others (n=4) had used velcro material to secure the prosthetic to their underwear. Some women (n=6) had made covers for their prosthetic from a soft cotton material to prevent chafing and to counteract the tendency for the prosthetic to stick uncomfortably to the chest wall. This was a particular problem in warm weather and in hot environments.

M4 " The proper one (prosthesis) can be uncomfortable especially in the summer or on holiday abroad as it gets sweaty and sticky next to your skin."

M4 " I prefer to use my comfie....I have one velcroed into my nighties....makes me feel more normal when I look down."

The problem respondents reported (n=16) focused on the fear that the prosthesis would fall out of their clothing when bending down. Because of this fear most of the respondents (n=14) did not wear low or scooped necklines to their clothing which some (n=6) felt impinged upon their choice of suitable clothes.
M17 "I live in fear of it falling out so I never wear anything low cut or even an open topped blouse."

There was general concern about underwear and swimwear with the younger women (n= 6) stating that they could no longer find suitable underwear and swimwear that was as skimpy and as attractive as they had previously been able to wear. To keep the prosthesis in place a fuller breast cup was required, with some women finding the sports bras offering the best for fit, comfort and security. A range of underwear and swimwear is available for mastectomised women but few (n= 7) reported buying this range of products. As one women said:

M6 "...that would be acknowledging that I'm different to myself, as long as I can go and buy my underwear at Marks and Spencers like most women do it doesn't feel so bad"

**Grieving for the lost breast**

The comments are drawn from the respondents in both groups. The mastectomised group had had all of their breast tissue removed, whereas with lumpectomy surgery women retain most of their breast tissue.

Every woman interviewed said they had grieved over the loss of her breast or part of it, bar one. This woman had had an immediate breast implant at the time of surgery and was clearly well adjusted to the impact of her operation which had caused minimal effect upon her sense of well being and body image. However, a typical response would be as follows:

M9 "The worst part was losing the breast. I still weep over it now."
L4 “I know it was only a part of my breast, but, it was my breast, my body. I know that bit of me is missing.”

Half of the mastectomised respondents reported that they continued to feel the loss. This caused distress if during the course of the interview they revealed other losses in their lives, e.g. bereavements since the operation.

**Negative Responses of Partners**

All the women from either group who had a partner or spouse felt their partner was deeply upset, shocked and dismayed by the diagnosis of breast cancer. This was true with one exception, this woman had received no support from her husband who acted in an indifferent manner on hearing his wife had breast cancer. They subsequently divorced a year after surgery, some years since. This woman was the most distressed of all the interviewees, often becoming tearful during the interview, expressing her deep sense of rejection and loneliness from which she did not feel she could ever recover. She made comments such as:

M2 "...he couldn't cope with me not being whole, so he switched off from me totally"

M2 "...if this terrible thing hadn't happened I'm sure we would still be together"

Overall, the responses of partners and husbands of respondents in either group had been very supportive. Some women (n= 5) said that it had made their partners realise the fragility of life itself when they found their wives lives threatened. Some of the women (n= 9) reported that their partners were more upset at the diagnosis of breast cancer than they were themselves. They felt their partners would have benefited from talking with other men who had supported their wives through the same process. The overwhelming response seems to have been one of the men feeling totally helpless and unable to ease the pain and trauma of the ordeal for their wives. As two woman expressed it:
"I just got on with it, he couldn’t deal with it and thought he was going to lose me"

"he was afraid for me for a long time after the operation, it was about a year before the pain left his eyes whenever he looked at me"

Of the respondents, the mastectomised group reported having more intense worries before the operation about how their husbands would respond to the loss of the breast and consequent scarring. The respondents that reported that their partners had seen the scar before leaving hospital (n=13) stated that this had greatly helped in their adjustment and that of their partner. They also reported fewer sexual difficulties. Initially, these women felt there was a problem of their partners not wishing to hurt them physically post-operatively, but all these respondents reported that their partners had adjusted very quickly.

The mastectomised women who had not shown their scar to their partner in hospital (n= 4) were experiencing more difficulty. They reported a significant change in their sexual behaviour since the operation. As one woman said:

"it is difficult to see yourself in the same way, he is totally at a loss to know how to handle the sexual side of things so as to cause you minimal discomfort and distress. You get into a cycle of anxiety where nothing is said but a lot of anxiety is being felt on both sides. He wants to make love to you, as you do to him but this mastectomy thing gets in the way and you end up saying and doing nothing - a stalemate"

One interesting observation was made with one woman who's unemployed son had been more involved than her husband in her aftercare in the weeks following surgery. She reported that she now has no difficulty in her son seeing her scar but has extreme difficulty in allowing her husband to see her scar.
Other women (n= 4) told of how if sex is initiated by their partner they rearrange things to hide their scar etc. For example, covering up the site of the operation with a pillow or keeping their top/T shirt on so their partner would be less aware of the operation scar and breast loss. Attempts at normalising their sexual lives was a central component of all the sexually active women in the study. There was a strong need to still be seen as desirable by their partner, hence the need for feminine lingerie and nightwear. Although, some women (n=2) said that they were less likely to initiate sexual contact than previously.

Many of the respondents (n= 32) from either group reported that prior to the operation they would have walked around the house, slept and had sex with their partners without needing to be covered up physically. This had radically changed for all the women in the mastectomy group except the breast implant respondent who said her sexual behaviour with her husband had not altered.

Some worry was expressed concerning a potential change in their relationship with their partner, a number of the women felt fearful that their partner would reject them.

M20 "...in favour of a real woman"

M20 "...I get more jealous now, since the operation in case he is staying with me because he feels sorry for me"

Feelings of loss of femininity
The worries about being less feminine than before were mainly expressed by the mastectomised group, but some of the lumpectomy group were also clearly concerned. For them the fear revolved around the possibility of further more mutilating surgery being needed at some point in the future if the cancer was to recur. Both groups reported that they had deep concerns about suffering the loss of the other breast (n=
32). For these women some degree of anguish was expressed at the thought of losing another breast and the consequences this might have upon their sense of being female.

M4 “I’d be such a freak if I lost my other breast as well, and to go through all that surgery again would be traumatic to say the least.”

L2 “I have been lucky this time, next time I could lose so much more. I pray it will not ever happen, but you just can’t tell.”

Much bitterness and resentment was expressed by almost all of the mastectomised group (n= 17) at how they have felt their sexuality and femininity has been compromised by having had a mastectomy. Some suggested (n= 5) that they were now incomplete as women, different to other women (n= 7) and abnormal (n= 3). To compensate for this some (n= 10) said they try to dress in a more feminine way such as no longer wearing jeans and a T shirt, they were more likely to wear a dress or skirt. Jealousy towards other women was expressed:

M14 "...I envy them their health, their wholeness as women, the fact they have two beautiful breasts. I look down and see I am not whole"

M20 “Different, I’ll say I feel different, I’m not female anymore, I’m a b----- freak.”

The way that mastectomised women react to other women with two breasts varied dependent upon whether or not they were in an established relationship. Women who were alone (n= 6) were more likely to report envy and jealousy. They also reported feeling less desirable, ugly or unattractive. Two of the women were exceptionally upset:

M3 “I feel ugly and sexually undesirable to any man.”

M20 "I feel like ...a freak"
Body Image Issues

Overall, the comments made during the course of the interviews showed that there is considerable distress concerning issues related to body image in women following any kind of breast surgery. This information would have been difficult to extract using traditional quantitative methods. The following table demonstrates the kind of issues surrounding body image raised by both groups during the interviews.

Table 6: A comparison of the sub-categories of body image problems between the two groups

<table>
<thead>
<tr>
<th>Mastectomy</th>
<th>Lumpectomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems with physical appearance</td>
<td>Less problems with physical appearance</td>
</tr>
<tr>
<td>Grief regarding the loss of the breast</td>
<td>Some grief regarding the loss of part of the breast</td>
</tr>
<tr>
<td>Problems with their partners response</td>
<td>Less problems with their partners response</td>
</tr>
<tr>
<td>Major problems with prosthesis</td>
<td>No problems with prosthesis</td>
</tr>
<tr>
<td>Many problems regarding loss of femininity</td>
<td>Minimal problems with loss of femininity</td>
</tr>
</tbody>
</table>

Clearly, there are some demonstrated commonalities between the two groups. However, the problems the mastectomised respondents report may be said to be greater by degree, than in the lumpectomy group. The primary differences they report are the extent of the surgical scarring undergone by mastectomised women and the need for these women to wear a prosthesis. However, the problems reported by the lumpectomy group are similar to that reported by the mastectomised respondents in many respects, and as such cannot be ignored.

The impact on attitude to life

Almost all of the respondents without exception (n= 37) said that the diagnosis of breast cancer had changed their attitude to life. Typical comments were:
"...I no longer save my money, I spend it on having a good time and the things I want in life"

"...I no longer plan for the future"

"...I live for today"

Comments were made such as:

"...I realised early on that I had survived the first hurdle and if I was to continue to survive I needed to be stronger (as a person) than ever before. People are sometimes surprised how much this has changed my attitude to life"

"..I used to take a lot of flak from my children and from my mother, now it's different, but then, I'm different"

Problems with preparing for surgery

One of the most difficult areas to get the respondents to talk about was the time between diagnosis and the operation. This often provoked a very emotional response. Most (n= 31) commented on the swift action taken by their G.P and Consultant with a matter of days from finding the abnormality in the breast and having the operation.

"...I didn't think about it, it all happened so quick"

"...it was such a shock and there was so much to think about with my family arrangements and so little time"

The promptness of action was considered to have necessary by all the respondents, however, some (n= 4) would have appreciated more time to think about what was irreversibly about to happen to them.
All respondents took the advice of their surgeon on the type of surgery. None of the respondents prior to surgery discussed the possibility of a breast implant or any corrective surgery prior to the operation being carried out, other than the woman who had an immediate breast implant which was on the suggestion of her surgeon.

Of the women that said that since their mastectomy they were interested in pursuing breast reconstruction, most felt that their Consultant was not amenable to the idea. One woman reported that after more than a year of requesting breast reconstruction her Consultant had finally agreed to perform the operation. Some felt this should have been discussed prior to the operation, feeling very angry towards their surgeon:

M12 "...I lacked the courage to tell him no"

M16 "...I was afraid if I didn’t let him operate on me then I would die"

M16 "...I would have liked to have known what the options were regarding breast reconstruction, I felt uncomfortable about asking, a fool, I thought perhaps they didn’t offer it because I'm not young and attractive. I didn’t even want to raise the issue for fear of ridicule"

The impact of radiotherapy

Although most of the women had received radiotherapy, only about half the women (n= 18) reported experiencing any problems, other than initial anxiety and tiredness, during the weeks of radiotherapy treatment.

Most respondents (n= 31) said they had felt anxious and nervous about attending for radiotherapy but the staff had soon put them at their ease. The most frequent complaint was the intense feelings of tiredness during the weeks they had undergone radiotherapy. With some respondents (n= 5) found radiotherapy more distressing than the operation, reasons given all focused on intense feelings of being alone, experienced
during the radiotherapy sessions. One woman was able to make the link between attending alone for radiotherapy and being alone at home after treatment.

M17 "...I suppose there had been a lot of fuss made when I had been admitted to hospital for the operation. And then everyone went back to work leaving me to deal with the 'cancer' part alone."

The life-threatening nature of cancer was apparent in some of their comments:

M2 "...it felt like I'd beaten it, I'd recovered from the operation, it felt good, then the letter arrived asking me to come for radiotherapy, I thought, God, I'm not going to get better"

L5 "...everyone has operations at some time in their life, don't they? Only cancer patients have radiotherapy (pause) suddenly I'd got cancer"

L3 "...the effect was devastating, I felt low with tiredness and depressed because I was having radiotherapy for cancer"

M8 "...I'd lulled myself into a false sense of security, I'd survived the operation for a malignant growth. Now I was being treated for cancer which was in a way more frightening"

The conceptual differences between having a 'growth' and having cancer for these women were clearly there. Further enquiry suggested that these women had hung on to a chance remark by others about having a growth removed and transposed it onto their situation.

L20 "I had friends who had growths removed, this was the same until I got to go for radiotherapy, it wasn't a growth anymore....it was cancer."
A few women (n= 9) found it very difficult to talk about their radiotherapy and became clearly distressed. Their distress concerned overwhelming feelings of being alone and frightened whilst having sessions of radiotherapy. Of these women two had sought out psychological help and two had a long spell on antidepressants. Others reported suffering panic attacks and higher levels of anxiety than they had previously known.

M4 “I can’t really talk about it, even now I remember how frightened I was...so alone, I saw a Counsellor for a long time after that.”

M6 “I had never needed stuff (antidepressants) for depression before.”
Clearly these women had experienced psychological problems during and after radiotherapy.

Follow-up visits to the hospital
All the respondents were required to attend for follow-up sessions with their Consultant Oncologist and Surgeon on a regular basis. Typically this will be at 3 monthly intervals over the first two years. All reported that they attended for these check-up visits and almost all alone or with a female family member or friend.

All respondents said that they were very nervous the first time they had attended and this was primarily because they feared more cancer being found. They also commented that they did not know what to expect and this caused worry to some women as did the need for quick results from the tests which women found reassuring.

L16 “I was very nervous, I was’nt prepared for it.....you know...not knowing what they (the medics) was going to do”

L7 “I was really concerned to know the result (of the tests) as soon as possible, the waiting was awful”
Other comments focused on the constant changing in the staff who examined them, some women (n= 21) expressed concern that the medics they saw changed so frequently it was difficult to have faith in them.

M4 "There is this constant need to keep retelling your story to yet another doctor with whom you have no relationship or affinity to, it is very difficult to feel confident with them"

For many of the women (n= 30) these visits took place in the outpatients department. Some women (n= 10) expressed their dissatisfaction with this as some of the other patients waiting to be seen were clearly very ill, this served as a reminder to these women that they themselves, although apparently well, were far from being considered healthy:

M14 "..you realise you are not out of the woods yet. It can be very upsetting to see very sick patients waiting to be seen by the Consultant when you feel so well yourself"

L13 "...you keep thinking this could be me soon"

Some of the women (n= 8) stated that they would prefer a specialised clinic for women with the Breast Care Nurses on hand to discuss things through with rather than leaving feeling there was a lot of unanswered questions.

Continued support
All of the respondents were members of the Cancer Support Group. Each had told of the need ultimately to seek out their own support network beyond that of their family and friends. The Breast Care Nurses proved to be an invaluable resource, particularly following surgery. The nurses were excellent disseminators of information about available support networks in the region. They themselves offered counselling and support to many women as well as offering support in weekly meetings and groups.
M10 "If I need to know anything, or say, have a worry about things, then they can often give me the answer. I see them at the weekly group, I can ask them then."

L1 "They put me in touch with the Cancer Support Group. They (the Breast Care Nurses) were invaluable when I first was diagnosed, very supportive and kind. I owe them a lot..... I was so upset at the time, chatting with them every week was a real help."

The women involved in this study had all sorted out varying degrees of support from the Cancer Support Group which works in close liaison with the service offered by the Breast Care Nurses. For some women (n= 16) their subscription to the Newsletter was sufficient and among these women the majority (n= 12) had never before been to the groups headquarters were the interviews were carried out. Others (n= 5) attended some of the groups offered, whilst others (n= 3) took an active part in the organisation and running of the Cancer Support Group activities. All found that the hospital service could offer little in the way of continued support, the Breast Care Service being over-subscribed.

M7 "I have never attended here before, but, it is nice to know it’s there if ever I should need it."

L2 "I do not want to be involved really, I view myself as well.... not having cancer, I prefer to just have the Newsletter."

Helpful and unhelpful experiences
Almost without exception (n= 38) the women reported that their families and partners had been most supportive throughout and this continued to be the case. Outside of the home and social circles of the women, the Cancer Support Group and the work undertaken by the staff there was particularly valued.
M1 “My family have been wonderful, my husband has been great about it all, all the way through.”

M2 “Outside of my family, the Cancer Support people have been lovely. I attended here for quite a while after my operation, they were so good.”

Similarly, the work of the Breast Care Nurses was seen as having a crucial part to play in the recovery process and continuing level of care offered.

M14 “I could not have cope without the Breast Care nurses, they were really helpful because they knew everything about it all. You didn’t have to say to them, they kind of knew already, I still see them now.”

About half of the respondents (n= 18) said that they had found resources outside of these support networks to be useful which was primarily through their faith or new friends and hobbies.

L17 “I found after a time I needed more than my family could offer. I needed to find a way through, my faith has helped me, especially at the start and I do much more for the church now than before.”

L19 “I have a lot of friends through the Cancer Support Group and hobbies that I didn’t make time for before which has been a great help. Takes your mind of things if your busy doing things you like.”

The most unhelpful experiences were reported as being the attitudes of some friends, family and especially acquaintances who had reacted to their illness by withdrawing or avoiding contact with them since the operation. One woman said:

M14 "...people I had known for years started to avoid me, at the school gates we used to chat together, now they cross the road to avoid me."
M6 "...I had a cup of tea with my friend two weeks after the operation, a regular occurrence, nothing out of the ordinary, I sensed my friend was anxious about something and then I realised she put my cup to one side to wash it up separately. Whenever I go there now she always gives me 'my cup.'"

M6 "Yes, it has altered my friendship with her, she was my best friend for thirty years, now I feel contagious in her company."
DISCUSSION

This study has attempted to highlight some of the problems women cope with after breast surgery. The study has shown how the problems differ in severity, dependant upon the kind of operation performed and has highlighted these trends. Although many authors have reported upon the psychological sequelae following mastectomy procedures (Maguire et al, 1978, Maraste et al, 1992), few have investigated the differences between surgery types (Gotteschalk & Hoigaard-Martin, 1986, de Haes et al, 1986). Whilst early studies have treated the two surgical procedures under the same banner of mastectomy, the present study has attempted to draw out the similarities and differences between the two groups using a multi-methodological approach.

Similarities and Differences between Mastectomy and Lumpectomy

The groups proved to be homogenous in some respects. They displayed no significant differences in age at the time of surgery, current age, years since surgery, or marital status. Against this backdrop of similarities, further similarities and some apparent differences will be discussed.

Some studies have suggested that mastectomy is more damaging psychologically than lumpectomy (Maguire et al, 1978, Morris et al, 1977, Dean, 1987). The present findings demonstrate that this is not always be the case. Similarities were found between women that had undergone either kind of surgery. For example, the groups did not differ on some of the variables tested such as the impact of the event, levels of self esteem and state and trait anxiety. Indeed, they did not differ significantly in their problem-focused ways of coping. Although, both groups reported very low levels of self esteem indicating that either operation may negatively impact upon self esteem. These results may be to some extent indicative of the homogeneity of the test population used in the present study. However, one explanation for this similar finding may lie in a counter-balance between the
psychological distress following mastectomy and greater fear that cancer may return in lumpectomised women. Some researchers (Fallowfield, 1990, Maguire, 1989 and Meyer, 1989) have already reported a greater fear of recurrence of cancer in women who had a lumpectomy than a mastectomy. As Fallowfield (1990) proposed, there is perhaps little difference in psychological morbidity levels between the two groups. However, further research is warranted into the different reasons that underpin and fuel such psychological distress.

Furthermore, there were no significant differences between the two groups on the IES measuring the cognitive components of trauma. Although, the results failed to reach a level of significance on the sub-scales (Avoidance and Intrusion) of the IES, there was a trend in the data towards significance. This may give an indication that both groups could be traumatised by their surgery and with a larger sample population, this may have emerged.

Interestingly, there was an emerging trend in the IES data for the mastectomised women to be more avoidant than the lumpectomy group, which is similarly reflected in their comments about their physical appearance. This trend suggested the possibility of the traumatic psychological impact of the surgery being continually re-experienced by remaining in active memory (McFarlane, 1992). It is tentatively suggested here that this may show that integration of the event into the cognitive schema (Horowitz, 1986) may not be taking place with this group. It is also suggested that this could be due to the constant physical reminder of surgery, apparent in the scarring. Thus, psychological recovery from the event of mastectomy could be impeded. This trend in the data could be linked with the work of Creamer et al (1992) who suggested that cognitive processing of such a traumatic event needs to take place before recovery can be achieved. However, such embryonic ideas require empirical research with a larger sample population.
The work of Lazarus and Folkman (1984) may be complimented by the findings of the present study. The results of this study show that although mastectomised women were more distressed about issues relating to negative body image, lumpectomised women were possibly more likely to engage in cognitive distortions, that is wishful thinking, avoidance, etc. Such avoidant, maladaptive ways of coping could, therefore, be linked to results found by Horowitz (1986), McFarlane (1992) as well as Creamer et al (1992). The evidence of the present findings suggest that breast surgery possibly challenges an individual’s cognitive schema about the world and how they understand it (Horowitz, 1986). Therefore, memories of breast surgery as a traumatic event may be in active memory, producing intrusive cognition’s. These intrusive cognition’s and thoughts are perhaps avoided in active memory as a way of coping with the mental distress (McFarlane, 1992). The processing of the traumatic event of breast surgery and it’s consequent uncertainty about continued health and survival is effectively prevented, therefore inhibiting recovery (Creamer et al, 1992). Again, such ideas need further evaluative research to clarify or verify what may be happening.

It is suggested here, that psychological therapy directly addressing the fact that women who have had breast surgery cope with an uncertain future would be useful. Therapy that promotes and advocates appropriate coping strategies may be helpful (Wong, 1992) leading to a better post-surgical adjustment.

Coping styles and the type of operation

No significant differences could be found between the two groups with respect to problem-focused styles of coping. This showed that the sample population was just as likely to use direct action to modify or minimise the effect or impact of the problems they were experiencing. Therefore, this sample population may be attempting to resolve their
problems by trying to control their thoughts and feelings (Lazarus and Folkman, 1984), which is an important part of the psychological healing process. However, this finding requires further evidence from a larger pool of respondents.

The lumpectomy group had significantly higher scores regarding blaming themselves for their illness, than the mastectomy group, a finding that is difficult to interpret. Furthermore, when the data from the two groups were analysed together, self-blame was the only indicator of general psychopathology. Again, this finding is difficult to interpret, but may have implications for the psychological treatment of breast cancer patients. The model proposed by Lazarus and Folkman (1984) rests on the assumption that maladaptive ways of handling difficult situations, such as blaming oneself for the illness, increase rates of depression and anxiety. Therefore, this is an area on which therapy needs to focus with the women who have lumpectomy surgery.

No significant differences could be found between the two test groups in relation to wishful thinking as a coping style. This may reflect that both groups are engaging in similar behaviours. Although, there is a non-significant trend in the data, for lumpectomised women to report wishful thinking as a coping style more frequently than mastectomised women. Similarly, there is a non-significant trend for the lumpectomy group to use avoidance as a way of coping more often than the mastectomised group. The work of Jelicic et al (1993) and Kaplan & Sadock (1985) regarding denial as a coping strategy may be linked to the coping style of wishful thinking. The link between avoidance and wishful thinking as a form of denial has implications for women who have breast surgery. The possibility that wishing things were different, the avoidance of intrusive cognition’s combined with denial of the reality of the situation, may be the maintaining factors fuelling psychological distress and morbidity. This area of research requires further investigation to achieve any clarity, and is an interesting topic of future research.
Body Image Issues and the type of operation

A high level of inter-rater reliability was obtained in the present study with respect to the classification, coding and categorisation of statements concerning negative body image issues. The findings of the present study revealed considerably more statements being made by the mastectomised group. The total score for the statements the women made about their body image was significantly correlated to the GHQ scores. On the one hand, the number of statements made may be said to be related to psychiatric caseness as measured by the GHQ. On the other hand, there is also the possibility that this is related to negative cognitive set.

However, this study has investigated only the negative statements made appertaining to body image which are only a proportion of the overall number of statements. Consequently, had the number of positive and negative statements been evaluated and compared this would have greatly strengthened the present findings. Furthermore, there has been no measure of the intensity of feelings about body image issues. Therefore, there are some difficulties with interpreting the results of the present study, because, respondents who have a higher number of body image distress statements may not be reflecting a higher level of distress. Therefore, the number of statements made may be considered only to be representative of the distress women report about body image problems.

The results indicate that almost a third of the statements the respondents made were about the problems they experienced with their prosthesis. When these statements were removed from the analysis of the data, the mastectomy group still made twice as many negative statements than the lumpectomy group. The hypothesis that the number of negative body image statements would be higher in respondents who had undergone mastectomy rather than lumpectomy is upheld. The findings of the present study reveal considerably higher and significant levels of psychological distress regarding issues revolving around body image in mastectomised women.
Maguire et al (1983) reported on the long term effects of mastectomy with respect to avoidance and compromisation of body image. Similar findings are presented in this study. Avoidance behaviour such as undressing in the dark, feeling uneven in their body and seeing their own naked reflection were all comments reported by the mastectomised respondents of this study. These findings compliment the work of Maguire et al (1983) who reported that mastectomised women were unhappy about the scarring, avoided their own naked form and suffered constant distress because of these problems. In addition, the current study confirms the work of Hopwood & Maguire (1988) who reported an enduring sense of permanent change in body image that mastectomised women feel unable to overcome. Although, the respondents that had lumpectomy were less avoidant about their appearance, to some degree, this was also true for them.

Similar to many past studies the current study identified that for many women who have breast surgery a sense of a loss of femininity is problematic post-surgery and does not diminish over time. As Polivy (1977) reported, femininity and self esteem are interrelated, therefore, the psychological effects of surgery may not transpire for some time following surgery. Hopwood and Maguire (1988) reported that anger, envy and jealousy expressed towards women with two breasts was intense in it’s expression giving rise to a very high level of distress, echoed in the present research. It is argued here that the expression of these emotions towards other women with two breasts is a maladaptive way of coping with the loss of their own breast.

The present study found that mastectomised women report problems in coping with the loss of their breast and this continues many years after surgery, possibly because they fear further breast loss. This was greatly compounded by any other losses that had been
experienced, such as bereavements, etc., which is an important factor for consideration in any therapeutic intervention with this population.

Although, some of the lumpectomy group reported problems about their breast loss, clear and significant problems were apparent in the comments made by the mastectomised respondents. This issue had previously been addressed by Hopwood & Maguire (1988) who reported similar findings. Although research is limited in this area, Maguire (1990) has more recently suggested that this area is often overlooked as surgeons are reluctant to enquire how women feel about the loss of their breast. It is suggested here that this reluctance may also extend to other professionals and researchers and may explain why there is a paucity of literature in this area.

The findings of Maguire et al (1983) who reported that 24% of mastectomised women were dissatisfied with their prosthesis are questioned by the current research. The present study revealed that almost all of the mastectomised respondents reported some degree of dissatisfaction, shown in the fact that approximately one-third of all the statements made by the mastectomised group concerned their prosthesis. Most often the women reported dissatisfaction with the fit, weight and comfort of their prosthesis. This would indicate a much higher percentage of women are unhappy with their prosthesis than previous studies have uncovered. Future research could focus on behavioural approaches to de-sensitise women to using a prosthesis in the early stages of recovery from surgery.

Furthermore, extreme anger was expressed by some respondents concerning the need to wear a prosthesis. The work of Goffman (1963) who commented upon the negative impact of having a compromised sense of identity following trauma such as mastectomy is given credibility in the light of the findings. As Kaplan (1983) suggested, the wearer may
perceive themselves as devalued by the wearing of a prosthesis. Feeling devalued as a woman is possibly being expressed by anger about the need to wear a prosthesis. Thus, the emotional impact of such a discrediting position may manifest itself in maladaptive, emotion-focused ways of coping (Vitaliano et al, 1985).

The present study thereby offers some limited support for the theories and models of coping proposed by Horowitz (1986), McFarlane (1992) and Creamer et al (1992).

Coping with psychological distress

It was hypothesised that maladaptive, emotion-focused styles of coping would be significantly related to negative body image statements, general mental health as measured by the GHQ, anxiety and the cognitive impact of the event. The findings were mainly non-significant with only the GHQ giving indication of differences between the mastectomy and lumpectomy groups. This showed that mastectomised women were reporting higher levels of dissatisfaction about their general mental health than the lumpectomised group. In addition, the overall recorded numbers of negative body image statements were shown to be significantly correlated to the GHQ measure in mastectomised women, indicating psychiatric caseness.

The advantage of using a coping measure when investigating problems in this population has been demonstrated (Heim et al, 1993). This is because it would be advantageous for changes in coping style to be measured over time. Such insight may be useful in relation to developing therapeutic approaches based on encouraging healthy coping strategies. Although, in the present study only one significant result was obtained using the WOC there were some significant trends in the data that may emerge more clearly with a larger sample population.
In the present study blaming oneself for the disease as a maladaptive way of coping was significantly related to the amount of negative body image statements reported by lumpectomised women. This would seem to indicate the clinical importance of focusing upon self blame in therapeutic interventions with lumpectomised women more so than in mastectomised women. Further research using larger samples may be helpful in providing clinical evidence of maladaptive ways of coping which can assist the clinical judgement and expertise of clinicians working in this field in the future.

Impact on Marital Status and Marital Satisfaction

It was hypothesised that the kind of surgery performed would have an impact on marital satisfaction. This hypothesis is not upheld by the present study as no differences could be found in reported levels of marital satisfaction in either group. Similarly, no differences could be reported in levels of general health, anxiety or the impact of the event between the married and cohabiting members and the single, divorced and widowed members of the two surgical groups.

Previous work by Omne-Ponten et al (1993) indicated that married or cohabiting women are less distressed by breast surgery than respondents who are single, widowed or divorced. Levels of anxiety, general mental health and the cognitive impact of the event were unaffected in the current research as to whether a person was married, cohabiting, widowed, single or divorced. However, in the present study most of the women were in long term relationships. The number of women without a partner was very limited, therefore, any interpretation of the results needs to take this factor into account.
Most of the married or cohabiting respondents reported that their partner reacted well to the physical consequences of their surgery. Of particular note, are women who's partners see the site of the scar early after surgery, e.g. when they were still in hospital, they reported less avoidance behaviour than many of the women studied. On the other hand, this was not the case for respondents who had avoided showing their partner the operation site. These respondents said they would be upset if their partner were to see the scarring. Some of these women had never allowed their partners to see the site of the operation at all. This is potentially an area for future research, it has implications for behavioural desensitisation programmes being developed for women and their partners. These programmes could be aimed at desensitisation to the scarring, before women are discharged from hospital.

Avoidance of showing sexual partners the site of the operation could account for the similar findings reported by Northouse (1989) and Derogatis (1980). Northouse found that some women and their partners find the adjustment to scarring very difficult. This in turn effects their marital and sexual relationship (Derogatis, 1980). This author highlighted sexual functioning and body image as interrelated components of self image. The present study gives some indication from where the sexual difficulties reported in breast surgery patients may stem. It also compliments the work of Jamieson, (1978) and Maguire et al (1978) who reported that sexual functioning may be compromised after surgery of such an intimate nature. However, it needs to be borne in mind that the quality, intimacy, degree of trust, respect and overall strength of the relationship are factors which need consideration. These factors would greatly influence the outcome of any therapeutic intervention.

If the pertinent issues for each individual or couple are identified and addressed early after surgery, much could be achieved to relieve the distress of mastectomised women and their partners. It is suggested here, this could be via marital or psycho-sexual counselling,
although currently there seems to be a dearth of trained Counsellors and Breast Care Nurses with these skills (Crockford et al, 1993). Furthermore, the lack of support for partners and families at the time of diagnosis and beyond, as they struggle to come to cope with their own feelings is also noted by the present study. Thus, this formulates an area for future research. It is suggested here that psychological help for partners and families would be a useful addition to present service provision.

**Age Factors**

The suggestion by Maguire (1975) that age could be an important factor in the psychological sequelae of breast surgery is given some support by the present findings. Although, this needs to be interpreted with caution due to the low numbers of respondents who were under forty years of age. Similarly, Meyerowitz (1980) also reported less psychological distress in older women than younger breast surgery patients.

Regrettably in this test population some of the younger women reported that their G. P's had not taken prompt action following the discovery of the lump in their breast. The younger women reported they were told it was unlikely to be cancerous because of their young age. The younger mastectomised women externalised blame for the mastectomy to their G.P. This would suggest further studies are needed with this population concerning internalised versus externalised locus of control, as well as differences in coping styles.

**Coping with Treatment Processes**

Many of the women at interview reported feeling unhappy about their medical treatment since the time of their operation. One area of regret for some women was that they had not been aware of all of the options prior to surgery. Other areas of concern were identified as
radiotherapy treatment and the follow-up sessions needed to check on their progress post-surgery.

Some of the respondents reported at interview that they felt they had not received sufficient information regarding the kinds of surgery and the availability of breast reconstruction. The work of Cohen & Lazarus (1973), Mechanic (1979, 1980, 1983) and Miller et al. (1983, 1988) has highlighted the usefulness of relevant information for some women in helping to cope with surgery. Clearly, the news of a breast cancer diagnosis causes disruption and upset as women face mutilating, yet lifesaving, surgery. Support at this time is critical from physicians, surgeons and nursing staff (Meyerowitz, 1993). Help in decision-making is an important aspect of care at this time as decisions need to be made quickly because of the nature of the problem. However, it is suggested, that women may not know of all of the options available to them at the time of surgery or have the time to consider the options. Many respondents in the present study reported that they feared ridicule if they had asked about breast re-construction, this became a source of much regret later. This study therefore has highlighted retrospectively the value of pre-operative information giving, counselling and psychological support.

From the findings of this study, it is clear the psychological impact and realisation of having had cancer, comes when they start their course of radiotherapy. Recently, Maraste et al. (1994) noted anxiety in women at the start of a course of radiotherapy, commenting that the role of radiotherapy and it’s impact, has yet to be fully explored. The present study echoes the comments of Maraste et al, but, offers the suggestion that such anxiety may stem from the realisation of their cancer status coinciding with the start of radiotherapy treatment.
The present study highlights the difficulties experienced by some women when they begin radiotherapy for breast cancer. For those in denial (Polivy, 1977) of their cancer status the realisation of the long term, life threatening nature of the disease must have a devastating effect. Denial may only be a protective psychological strategy used initially to cope with the surgery. It is suggested here that prior to radiotherapy women may deny their cancer status because many other conditions require surgical intervention. However, only cancerous conditions require radiotherapy treatment. It is argued here, that for some women the reality of cancer may be being denied up to the point of radiotherapy treatment. Radiotherapy may therefore be especially traumatic for women who attend sessions of radiotherapy unprepared and without adequate social support. Thus, this illuminates service provision needs for the future and another prospective area of research.

Polinsky (1994) reported on the enduring extent of psychological distress following breast surgery, noting its long term effects up to 32 years post surgery. Polinsky also commented upon the way that medical follow-up sessions with surgeons and oncologists cause anxiety and distress that does not abate over time. Similar findings are reported here, even 6 years after surgery which was the mean years since surgery in the present sample, women reported feeling upset about their attending such appointments. This was mainly because they serve as a constant reminder of their illness. The women of this study have indicated how this might be improved, with a more consistent level of service provision and specialised services for women following breast surgery. This is an area that is open to new and innovative ideas about future service development and provision.

Many of the women that took part in this study commented how their attitude to life had changed since their diagnosis, many becoming aware of the fragility of their lives. Although women found partners and family supportive, some of the women found the avoidant reaction of some of their friends and acquaintances hurtful and inappropriate.
Dealing with these compounding factors may explain why some women having undergone breast surgery do not cope with their changed circumstances (Goffman, 1963). As a result they continue to suffer anxiety, depression and problems with coping long after the operation (Polinsky, 1994).

**Implications of the study**

In summary, it would appear that women who undergo breast surgery for cancer have to cope with long and enduring problems. To this end good service provision and organisations such as Cancer Support Groups have an invaluable role in providing care and support throughout the years after surgery. Much can be learnt from programmes such as Reach for Recovery (Willets, 1994) a service that encompasses all aspects of breast care from self examination to support for women throughout diagnosis, treatment and beyond. Organisations such as these enable women to cope with their lives long after the memories of the trauma have faded for family and friends.

Attention is drawn in particular to the need for G.P.s and other health professionals to take seriously the concerns of younger women who present with breast problems. Their younger age does not preclude them from developing breast cancer. As some of the younger mastectomised women of this study had experienced difficulties with getting their GP’s to refer them on to Consultant Surgeons, this is an important area to be addressed by local services.

The present study also highlights the need for more specialised Nurses, Counsellors and Clinical Psychologists working in this field (Meyerowitz, 1993, Crockford, et al, 1994). Furthermore, informing surgeons and physicians about the long term implications of breast surgery would be useful in highlighting the potential problems women may have following breast surgery. This is clearly an issue for their professional training bodies to address. Indeed, the future may hold the further development of skin-saving mastectomy
(Carlson, 1996) and re-construction techniques that could do much to prevent the psychological trauma of mastectomy.

The psychological distress highlighted from the present study would indicate that psychological help and support would be appropriate with this group of women and could take many forms. Most importantly, there would need to be an acknowledgement of the severity of some of the problems women have after surgery of this kind. In addition, a greater awareness that help is needed for most women to come to terms with some of the negative implications of such surgery. Consequently, there would seem to be a need for professionals such as surgeons, nurses, G.Ps and oncologists to work alongside psychologists, counsellors and specialist breast care nurses to increase awareness about the problems suffered post-surgically. Such liaison between professionals could enable a more holistic approach of care to evolve.

Specifically, it is shown that there is a need for staff to be better trained to deal with women during the time they are in hospital in helping them come to terms with their altered state of body image and scarring. Furthermore, better information may be given prior to surgery so that women understand their options and in doing so can gain some degree of control over their lives during a time of great fear and vulnerability.

It is also suggested here that anxiety management techniques and good coping strategies could be taught to help reduce anxiety and enhance better coping styles. Furthermore, as many of the women who undergo surgery of this kind are in intimate relationships there would seem to be good reason to offer relationship counselling and psycho-sexual therapy where requested. Such support in the early stages of recovery could prevent future difficulties. This a study has highlighted that psycho-sexual and relationship difficulties may be centred around body image problems and maladaptive ways of coping with their lives after this kind of surgery.
The findings confirm that either kind of breast surgery can lead to psychological problems. The problems may differ but the manifestation of those problems can emerge in similar levels of anxiety, psychological distress and psychopathology. Future research could focus on the impact of the surgery as a traumatising experience and how women come to terms and cope with the lifelong effects of such surgery. In addition, research into the impact breast cancer has upon partners and family is warranted. Their psychological needs have so far been ignored.

Other areas of research for the future include investigation into how women cope with radiotherapy. Much could be done to improve service delivery. Similarly, the follow-up sessions could formulate an interesting area for service development research into how to improve the services offered. It is argued here that these are interesting and productive areas of research that are long overdue.

Any discussion of the results needs to take account of the limitations of the study. The sample population was drawn from a wide pool of members of a local Cancer Support Group. Therefore, their views can only be said to be representative of the women that are members of such support agencies and in as much biased within the wider population of mastectomised and lumpectomised women. Of those women who self-selected to participate, a number were excluded because they were still in active treatment or had suffered a recurrence of cancer. In the event, there were fewer respondents than had originally been envisaged. There is also a question surrounding the relationship between the number of statements women made at interview and reported distress. Although the number of negative statements made correlated well with psychiatric caseness as measured by the GHQ this may not accurately be reflecting distress. This may be because this study has only assumed that the more distressed the individual is the more likely they are to report that distress. A measure of intensity of feelings would have been a useful addition to the study as would a comparison between negative and positive statements made.
In addition, the questionnaires and inventories used proved to be problematic due to the questionable reliability of some of the measures with the sample population. This meant that some of the results obtained could not be used, therefore, these measures were excluded from the present study. Furthermore, as no pre-surgery measures were available only the differences between the two groups could be measured. Therefore, it can not categorically be said that the differences found are a specific result of surgical intervention, although the study has shown some significant and important findings.

In summary, this study has highlighted the problems that women are continuing to cope with following breast surgery. The multi-methodological approach has proved to be a useful way of examining the issues. Using a quantitative perspective has enabled comparisons to past studies and set the study within the context of empirical research. Whilst, the qualitative focus on some of the relevant issues has enabled the research to reach a deeper level of understanding of what it means to have had breast surgery. Bringing these two approaches together has illuminated the fact that many women struggle to cope well with their lives following such surgery.

Finally, using this combined research technique in the present study has identified issues surrounding a woman's body image as major life stressors following surgery. Furthermore, the treatment processes of radiotherapy and follow up sessions are identified as additional stressors. The help women can get from Breast Care Nurses and Cancer Support is highlighted and the valuable contribution they make in helping women to cope after breast surgery. In conclusion, the study has generated some notions for further research, highlighted areas of interest to clinicians working in this field and provided some insight into the problems women experience post breast surgery.
REFERENCES


Appendix 1

Dear Reader

I am currently involved in research into the post-operative effects of breast surgery. I would be grateful if any of you could offer me some support by electing to be part of my research.

The research involves filling in some questionnaires and a short interview with myself. I would hope that this would not take up too much of your time.

If you feel you would like to contribute can you please contact me so that I can arrange to see you.

You can fill in the slip below or contact me directly on tel: ...............

Thank you for your support

Yours Sincerely

________________________________________________________________________

Name.....................................Address..............................................................

Tel No:................................................

I agree to the Researcher contacting me regarding their research.

signed.................................................................
I would like you to consider an event that you have experienced at work in the last two weeks which you have found to be stressful. Please read each item below and indicate, by circling the appropriate category, to what extent you used it in the situation you have chosen.

<table>
<thead>
<tr>
<th>Item</th>
<th>Not used</th>
<th>Used some</th>
<th>Used quite a bit</th>
<th>Used a great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Just concentrated on what I had to do next - the next step.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. I tried to analyse the problem in order to understand it better.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Turned to work or substitute activity to take my mind off things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. I felt that time would make a difference - the only thing to do was wait.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Bargained or compromised to get something positive from the situation.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. I did something which I didn't think would work, but at least I was doing something.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Tried not to get the person responsible to change his or her mind.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Talked to someone to find out more about the situation.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Criticized or lectured myself.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. Tried not to burn my bridges, but leave things open somewhat.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Hoped a miracle would happen.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Went along with fate; sometimes I just have bad luck.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Went on as if nothing had happened.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
### Ways of Coping (continued)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Not used</th>
<th>Used somewhat</th>
<th>Used quite a bit</th>
<th>Used a great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.</td>
<td>I tried to keep my feelings to myself.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15.</td>
<td>Looked for the silver lining, so to speak; tried to look on the bright side of things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16.</td>
<td>Slept more than usual.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17.</td>
<td>I expressed anger to the person(s) who caused the problem.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18.</td>
<td>Accepted sympathy and understanding from someone.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19.</td>
<td>I told myself things that helped me to feel better.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20.</td>
<td>I was inspired to do something creative.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21.</td>
<td>Tried to forget the whole thing.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22.</td>
<td>I got professional help.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23.</td>
<td>Changed or grew as a person in a good way.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24.</td>
<td>I waited to see what would happen before doing anything.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25.</td>
<td>I apologised or did something to make up.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26.</td>
<td>I made a plan of action and followed it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27.</td>
<td>I accepted the next best thing to what I wanted.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28.</td>
<td>I let my feelings out somehow.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>29.</td>
<td>Realized I brought the problem on myself.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30.</td>
<td>I came out of the experience better than when I went in.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
### Ways of Coping (continued)

<table>
<thead>
<tr>
<th></th>
<th>Not used</th>
<th>Used somewhat</th>
<th>Used quite a bit</th>
<th>Used a great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>31.</td>
<td>Talked to someone who could do something concrete about the problem.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>32.</td>
<td>Got away from it for a while.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>33.</td>
<td>Tried to make myself feel better by eating, drinking, smoking, using drugs or medication, etc.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>34.</td>
<td>Took a big chance or did something very risky.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>35.</td>
<td>Tried not to act too hastily or follow my first hunch.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>36.</td>
<td>Found new faith.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>37.</td>
<td>Maintained my pride and kept a stiff upper lip.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>38.</td>
<td>Rediscovered what is important in life.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>39.</td>
<td>Changed something so things would turn out all right.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>40.</td>
<td>Avoided being with people in general.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>41.</td>
<td>Didn't let it get to me; refused to think too much about it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>42.</td>
<td>I asked a relative or friend I respected for advice.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>43.</td>
<td>Kept others from knowing how bad things were.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>44.</td>
<td>Made light of the situation; refused to get too serious about it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>45.</td>
<td>Talked to someone about how I was feeling.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>46.</td>
<td>Stood my ground and fought for what I wanted.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
### Ways of Coping (continued)

<table>
<thead>
<tr>
<th></th>
<th>Not used</th>
<th>Used somewhat</th>
<th>Used quite a bit</th>
<th>Used a great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>47. Took it out on other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>48. Drew on my past experiences; I was in a similar situation before.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>49. I knew what had to be done, so I doubled my efforts to make things work.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>50. Refused to believe that it had happened.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>51. I made a promise to myself that things would be different next time.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>52. Came up with a couple of different solutions to the problem.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>53. Accepted it since nothing could be done.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>54. I tried to keep my feeling from interfering with other things too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>55. Wished that I could change what had happened or how I felt.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>56. I changed something about myself.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>57. I daydreamed or imagined a better time or place than the one I was in.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>58. Wished that the situation would go away or somehow be over with.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>59. Had fantasies or wishes about how things might turn out.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>60. I prayed.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>61. I prepared myself for the worst.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>62. I went over in my mind what I would say or do.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
**APPENDIX 2**

**Ways of Coping (continued)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Not used</th>
<th>Used some-</th>
<th>Used quite a bit</th>
<th>Used a great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>63. I thought about how a person I admire would handle this situation and used that as a model.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>64. I tried to see things from the other person's point of view.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>65. I reminded myself how much worse things could be.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>66. I jogged or exercised.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>67. I tried something entirely different from any of the above. (Please describe).</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
REVISED IMPACT OF EVENTS SCALE

Below is a list of comments made by people after stressful life events. Please check each item, indicating how frequently these comments were true for you DURING THE PAST SEVEN DAYS. If they did not occur during that time, please mark the 'Not at all' column.

<table>
<thead>
<tr>
<th>COMMENT</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I thought about it when I didn’t mean to.</td>
<td></td>
</tr>
<tr>
<td>2. I avoided letting myself get upset when I thought about it or was reminded of it.</td>
<td></td>
</tr>
<tr>
<td>3. I tried to remove it from memory</td>
<td></td>
</tr>
<tr>
<td>4. I had trouble falling asleep because of pictures or thoughts about it that came into my mind.</td>
<td></td>
</tr>
<tr>
<td>5. I had waves of strong feeling about it.</td>
<td></td>
</tr>
<tr>
<td>6. I had dreams about it.</td>
<td></td>
</tr>
<tr>
<td>7. I stayed away from reminders of it.</td>
<td></td>
</tr>
<tr>
<td>8. I felt as if it hadn’t happened or it wasn’t real.</td>
<td></td>
</tr>
<tr>
<td>9. I tried not to talk about it.</td>
<td></td>
</tr>
<tr>
<td>10. Pictures about it popped into my mind.</td>
<td></td>
</tr>
<tr>
<td>11. Other things kept making me think about it.</td>
<td></td>
</tr>
<tr>
<td>12. I was aware that I still had a lot of feelings about it, but I didn’t deal with them.</td>
<td></td>
</tr>
<tr>
<td>13. I tried not to think about it.</td>
<td></td>
</tr>
<tr>
<td>14. Any reminder brought back feelings about it.</td>
<td></td>
</tr>
<tr>
<td>15. My feelings about it were kind of numb.</td>
<td></td>
</tr>
</tbody>
</table>
SELF-EVALUATION QUESTIONNAIRE

Developed by Charles D. Spielberger
in collaboration with
R. L. Gorsuch, R. Lushene, P. R. Vagg, and G. A. Jacobs

STAI Form Y-1

Name ___________________________ Date __________ S __

Age __________ Sex: M ____ F ____ T __

DIRECTIONS: A number of statements which people have used to
describe themselves are given below. Read each statement and then
blacken in the appropriate circle to the right of the statement to indi­
cate how you feel right now, that is, at this moment. There are no right
or wrong answers. Do not spend too much time on any one statement
but give the answer which seems to describe your present feelings best.

1. I feel calm ..............................................

2. I feel secure ..............................................

3. I am tense ..............................................

4. I feel strained ...........................................

5. I feel at ease ..............................................

6. I feel upset ..............................................

7. I am presently worrying over possible misfortunes ..............

8. I feel satisfied ...........................................

9. I feel frightened ...........................................

10. I feel comfortable ......................................

11. I feel self-confident ...................................

12. I feel nervous ...........................................

13. I am jittery .............................................

14. I feel indecisive ....................................... 

15. I am relaxed .............................................

16. I feel content ...........................................

17. I am worried ...........................................

18. I feel confused ...........................................

19. I feel steady ............................................

20. I feel pleasant ...........................................
SELF-EVALUATION QUESTIONNAIRE  
STAI Form Y-2

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you generally feel. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

21. I feel pleasant ......................................................... 0 0 0 0
22. I feel nervous and restless ......................................................... 0 0 0 0
23. I feel satisfied with myself ......................................................... 0 0 0 0
24. I wish I could be as happy as others seem to be ......................................................... 0 0 0 0
25. I feel like a failure ......................................................... 0 0 0 0
26. I feel rested ......................................................... 0 0 0 0
27. I am “calm, cool, and collected” ......................................................... 0 0 0 0
28. I feel that difficulties are piling up so that I cannot overcome them ......................................................... 0 0 0 0
29. I worry too much over something that really doesn’t matter ......................................................... 0 0 0 0
30. I am happy ......................................................... 0 0 0 0
31. I have disturbing thoughts ......................................................... 0 0 0 0
32. I lack self-confidence ......................................................... 0 0 0 0
33. I feel secure ......................................................... 0 0 0 0
34. I make decisions easily ......................................................... 0 0 0 0
35. I feel inadequate ......................................................... 0 0 0 0
36. I am content ......................................................... 0 0 0 0
37. Some unimportant thought runs through my mind and bothers me ......................................................... 0 0 0 0
38. I take disappointments so keenly that I can’t put them out of my mind ......................................................... 0 0 0 0
39. I am a steady person ......................................................... 0 0 0 0
40. I get in a state of tension or turmoil as I think over my recent concerns — and interests ......................................................... 0 0 0 0

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This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0, 1, 2 or 3) next to the one statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

<table>
<thead>
<tr>
<th>Number</th>
<th>Statement 1</th>
<th>Statement 2</th>
<th>Statement 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I do not feel sad.</td>
<td>I feel sad.</td>
<td>I am sad all the time and I can’t snap out of it.</td>
</tr>
<tr>
<td>2</td>
<td>I am not particularly discouraged about the future.</td>
<td>I feel discouraged about the future.</td>
<td>I have nothing to look forward to.</td>
</tr>
<tr>
<td>3</td>
<td>I do not feel like a failure.</td>
<td>I feel I have failed more than the average person.</td>
<td>As I look back on my life, all I can see is a lot of failures.</td>
</tr>
<tr>
<td>4</td>
<td>I get as much satisfaction out of things as I used to.</td>
<td>I don’t enjoy things the way I used to.</td>
<td>I don’t get real satisfaction out of anything anymore.</td>
</tr>
<tr>
<td>5</td>
<td>I don’t feel particularly guilty.</td>
<td>I feel guilty a good part of the time.</td>
<td>I feel quite guilty most of the time.</td>
</tr>
<tr>
<td>6</td>
<td>I don’t feel I am being punished.</td>
<td>I may be punished.</td>
<td>I expect to be punished.</td>
</tr>
<tr>
<td>7</td>
<td>I don’t feel disappointed in myself.</td>
<td>I am disappointed in myself.</td>
<td>I am disgusted with myself.</td>
</tr>
<tr>
<td>8</td>
<td>I don’t feel I am any worse than anybody else.</td>
<td>I am critical of myself for my weaknesses or mistakes.</td>
<td>I blame myself all the time for my faults.</td>
</tr>
<tr>
<td>9</td>
<td>I don’t have any thoughts of killing myself.</td>
<td>I have thoughts of killing myself, but I would not carry them out.</td>
<td>I would like to kill myself.</td>
</tr>
<tr>
<td>10</td>
<td>I don’t cry any more than usual.</td>
<td>I cry more now than I used to.</td>
<td>I cry all the time now.</td>
</tr>
<tr>
<td>11</td>
<td>I am not interested in other people.</td>
<td>I am less interested in other people than I used to.</td>
<td>I have lost most of my interest in other people.</td>
</tr>
<tr>
<td>12</td>
<td>I make decisions about as well as I ever could.</td>
<td>I put off making decisions more than I used to.</td>
<td>I have greater difficulty in making decisions than before.</td>
</tr>
<tr>
<td>13</td>
<td>I don’t feel I am any worse than anybody else.</td>
<td>I am critical of myself for my weaknesses or mistakes.</td>
<td>I blame myself all the time for my faults.</td>
</tr>
<tr>
<td>Item</td>
<td>Description</td>
<td>Score</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>I don't feel I look any worse than I used to.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>I am worried that I am looking old or unattractive.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>I feel that there are permanent changes in my appearance that make me look unattractive.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>I believe that I look ugly.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Golombok Rust Inventory of Marital State (GRIMS) Questionnaire

Before beginning the questionnaire, please complete this section in block capitals.

NAME: ............................................. SEX: .............
DATE: ............. AGE (Years): ............. LENGTH OF RELATIONSHIP: ............. Years ............. Months
NAME OF PARTNER: .............................................

Instructions

Each statement is followed by a series of possible responses: strongly disagree (SD), disagree (D), agree (A), strongly agree (SA). Read each statement carefully and decide which response best describes how you feel about your relationship with your partner, then circle the corresponding response.

Please respond to every statement; if none of the responses seem completely accurate, circle the one which you feel is most appropriate. Do not spend too long on each question.

Please answer the questionnaire without discussing any of the statements with your partner. In order for us to obtain valid information it is important for you to be as honest and as accurate as possible.

All information will be treated in the strictest confidence.

1. My partner is usually sensitive to and aware of my needs ............................................. SD D A SA
2. I really appreciate my partner’s sense of humour ............................................................... D D A SA
3. My partner doesn’t seem to listen to me any more ............................................................ D D A SA
4. My partner has never been disloyal to me ........................................................................ D D A SA
5. I would be willing to give up my friends if it meant saving our relationship ................ D D A SA
6. I am dissatisfied with our relationship ............................................................................. D D A SA
7. I wish my partner was not so lazy and didn’t keep putting things off ............................... D D A SA
8. I sometimes feel lonely even when I am with my partner .............................................. D D A SA
9. If my partner left me life would not be worth living ...................................................... D D A SA
10. We can ‘agree to disagree’ with each other ...................................................................... D D A SA
11. It is useless carrying on with a marriage beyond a certain point ........................................ D D A SA
12. We both seem to like the same things ........................................................................... D D A SA
13. I find it difficult to show my partner that I am feeling affectionate ................................ D D A SA
14. I never have second thoughts about our relationship .................................................. D D A SA
15. I enjoy just sitting and talking with my partner ............................................................... D D A SA
16. I find the idea of spending the rest of my life with my partner rather boring ................ D D A SA
17. There is always plenty of ‘give and take’ in our relationship ........................................... D D A SA
18. We become competitive when we have to make decisions ............................................. D D A SA
19. I no longer feel I can really trust my partner ................................................................. D D A SA
20. Our relationship is still full of joy and excitement ......................................................... D D A SA
21. One of us is continually talking and the other is usually silent ....................................... D D A SA
22. Our relationship is continually evolving ......................................................................... D D A SA
23. Marriage is really more about security and money than about love ................................ D D A SA
24. I wish there was more warmth and affection between us ............................................. D D A SA
25. I am totally committed to my relationship with my partner ........................................ D D A SA
26. Our relationship is sometimes strained because my partner is always correcting me .... D D A SA
27. I suspect we may be on the brink of separation ............................................................. D D A SA
28. We can always make up quickly after an argument ....................................................... D D A SA

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APPENDIX 8

APPENDIX 9

SCALE ITEMS

The 10 items are presented as follows:

Below is a list of statements dealing with your general feelings about yourself. If you agree with the statement, circle A. If you strongly agree, circle SA. If you disagree, circle D. If you strongly disagree, circle SD.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>1</td>
<td>On the whole, I am satisfied with myself.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
</tr>
<tr>
<td>2</td>
<td>At times I think I am no good at all.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
</tr>
<tr>
<td>3</td>
<td>I feel that I have a number of good qualities.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
</tr>
<tr>
<td>4</td>
<td>I am able to do things as well as most other people.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
</tr>
<tr>
<td>5</td>
<td>I feel I do not have much to be proud of.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
</tr>
<tr>
<td>6</td>
<td>I certainly feel useless at times.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
</tr>
<tr>
<td>7</td>
<td>I feel that I'm a person of worth, at least on an equal plane with others.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
</tr>
<tr>
<td>8</td>
<td>I wish I could have more respect for myself.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
</tr>
<tr>
<td>9</td>
<td>All in all, I am inclined to feel that I am a failure.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
</tr>
<tr>
<td>10</td>
<td>I take a positive attitude toward myself.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
</tr>
</tbody>
</table>
Please read this carefully:

We should like to know if you have had any medical complaints, and how your health has been in general, over the past few weeks. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your cooperation.

**H ave you recently:**

| A1 | been feeling perfectly well and in good health? | Better than usual | Same as usual | Worse than usual | Much worse than usual |
| A2 | been feeling in need of a good tonic? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| A3 | been feeling run down and out of sorts? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| A4 | felt that you are ill? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| A5 | been getting any pains in your head? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| A6 | been getting a feeling of tightness or pressure in your head? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| A7 | been having hot or cold spells? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| B1 | lost much sleep over worry? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| B2 | had difficulty in staying asleep once you are off? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| B3 | felt constantly under strain? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| B4 | been getting edgy and bad-tempered? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| B5 | been getting scared or panickey for no good reason? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| B6 | found everything getting on top of you? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| B7 | been feeling nervous and strung-up all the time? | Not at all | No more than usual | Rather more than usual | Much more than usual |
**APPENDIX 9**

<table>
<thead>
<tr>
<th>HAVE YOU RECENTLY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C1</strong> - been managing to keep yourself busy and occupied?</td>
</tr>
<tr>
<td><strong>C2</strong> - been taking longer over the things you do?</td>
</tr>
<tr>
<td><strong>C3</strong> - felt on the whole you were doing things well?</td>
</tr>
<tr>
<td><strong>C4</strong> - been satisfied with the way you've carried out your task?</td>
</tr>
<tr>
<td><strong>C5</strong> - felt that you are playing a useful part in things?</td>
</tr>
<tr>
<td><strong>C6</strong> - felt capable of making decisions about things?</td>
</tr>
<tr>
<td><strong>C7</strong> - been able to enjoy your normal day-to-day activities?</td>
</tr>
</tbody>
</table>

| D1 - been thinking of yourself as a worthless person? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| D2 - felt that life is entirely hopeless? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| D3 - felt that life isn't worth living? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| D4 - thought of the possibility that you might make away with yourself? | Definitely not | I don't think so | Has crossed my mind | Definitely have |
| D5 - found at times you couldn't do anything because your nerves were too bad? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| D6 - found yourself wishing you were dead and away from it all? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| D7 - found that the idea of taking your own life kept coming into your mind? | Definitely not | I don't think so | Has crossed my mind | Definitely has |

A   B   C   D   TOTAL
Marital Status

Marital Status at time of operation

Current Age

Age at time of operation

Type of operation
How did you discover there was a problem with your breast?

How do you think the operation has effected you psychologically? If so, How?

Have you been upset by your physical appearance?

How do you feel when you look at yourself?
To what extent does this upset you?
If yes: would you say you have continued to be as upset by your appearance as you were in the beginning?

Do you feel lopsided or unbalanced in your appearance?

How has the operation changed you physically?

If you wear a prosthesis are you experiencing any problems with this at the moment? If so, what kind of problems? With fit? With weight? With comfort?

How satisfied are you with your prosthesis?

Do you have problems with clothes or underwear fittings? If so what are they?

Do you have any worries about being seen naked or topless?
Has your husband or partner seen your scar?
If not, why not?

If yes, how has he reacted to your scar?

What help could have been offered to your partner/husband at the time of your diagnosis and operation?

What would he have gained from this?

What was the worst thing for him to come to terms with?

Do you feel this is still the case?

Do you think your husband/partner is upset about you having lost part of your breast or losing your breast?
What is it that upsets him?

Does your husband/partner make any comment about your physical appearance because of the operation?

Would you say your husband/partner has been supportive since your operation? If so, how?

Has anything changed in your relationship as a result of the operation?

Has there been any significant change in the intimate nature of your relationship with your husband since the operation?

Have you grieved for the loss of your breast/part of breast?

Do you continue to be upset?

If so, what is it that upsets you?
Do you feel the operation has affected your sense of being feminine?
If so, how?

Do you think it has affected your sense of self?
If so, how?

What were your feelings about radiotherapy?

Did you notice any effect upon your mood during this time?
If so can you tell me more about this?

Do you attend for regular check-ups with your Consultants?
How do you feel about them?

Do you feel you are sufficiently supported by the hospital now your treatment is over?

How might this be improved?

What has been most helpful to you?
And the least helpful?

THANK HER FOR HER TIME/MAKE AWARE OF COUNSELLOR SUPPORT

ANY OTHER COMMENTS/NOTES
LIST OF THE VARIABLES

1. Age
2. Beck Depression Inventory
3. State Trait Anxiety Inventory - State Anxiety
4. State Trait Anxiety Inventory - Trait Anxiety
5. Eysenck Personality Inventory - Neuroticism Scale
6. Eysenck Personality Inventory - Extroversion Scale
7. Eysenck Personality Inventory - Lie Scale
8. Impact of Events Scale - Intrusion Score
9. Impact of Events Scale - Avoidance Score
10. Impact of Events Scale - Total Score
11. Rosenberg Self Esteem Questionnaire
12. General Health Questionnaire
13. Golumbok Rust Inventory of Marital Satisfaction
14. Body Image Score - Physical Appearance
15. Body Image Score - Prosthetics
16. Body Image Score - Loss of Breast
17. Body Image Score - Loss of Femininity
18. Body Image Score - Partners Responses
19. Body Image Score - Total Score
20. Ways of Coping - Problem Focused
21. Ways of Coping - Seeks Social Support
22. Ways of Coping - Blames Self
23. Ways of Coping - Wishful Thinking
24. Ways of Coping - Avoidance
<table>
<thead>
<tr>
<th></th>
<th>12</th>
<th>11</th>
<th>10</th>
<th>9</th>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. AGE</strong></td>
<td>-.12</td>
<td>-.01</td>
<td>-.31</td>
<td>-.27</td>
<td>-.19</td>
<td>.01</td>
<td>.08</td>
<td>-.27</td>
<td>-.07</td>
<td>-.12</td>
<td>-.07</td>
</tr>
<tr>
<td></td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>p.04</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td><strong>2. BDI</strong></td>
<td>.03</td>
<td>.13</td>
<td>.01</td>
<td>-.03</td>
<td>-.06</td>
<td>-.03</td>
<td>-.1</td>
<td>.41</td>
<td>.66</td>
<td>.69</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td><strong>3. STAI-S</strong></td>
<td>.05</td>
<td>.08</td>
<td>-.1</td>
<td>.17</td>
<td>-.17</td>
<td>.2</td>
<td>-.01</td>
<td>.33</td>
<td>.67</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
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<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td><strong>4. STAI-T</strong></td>
<td>.05</td>
<td>.07</td>
<td>-.1</td>
<td>.02</td>
<td>-.17</td>
<td>.16</td>
<td>.03</td>
<td>.36</td>
<td>NS</td>
<td>NS</td>
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APPENDIX 13

TABLE 4: CORRELATIONS BETWEEN WAYS OF COPING SUB-SCALES

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Name Not applicable

Marital Status Divorced

Marital Status at time of operation Married

Current Age 66

Age at time of operation 62

Type of operation Mastectomy

How did you discover there was a problem with your breast?

“I was in the shower when I felt a lump. It was a shock at the time, but I knew that I needed to see my G.P. as soon as I could. I have never really bothered to check my breasts for lumps, I suppose I thought it happened to other people. You never imagine it can happen to you.”

How do you think the operation has effected you psychologically? If so, How?

“Yes.” “It has affected me very badly. I was married but now I’m not. He left because of the mastectomy, we had not got a very good relationship to start with, the mastectomy was the final straw.”

Have you been upset by your physical appearance?

“Oh, yes very much so. I cried when I first saw the terrible scar, I know it was for my own good, after all I’m alive, but the scar still bothers me it’s so big, I try to hide it, not look down at it......I’m sure that they could have made a better job of it than they did....you know less of a scar.”

How do you feel when you look at yourself?

“When you get to our age these things are less important...How you look that is...”
To what extent does this upset you?
“Even now I cringe every time I touch it, whether purposefully or accidentally.”

If yes: would you say you have continued to be as upset by your appearance as you were in the beginning?
“Yes, I’ve been upset ever since.”

Do you feel lopsided or unbalanced in your appearance?
“Very much so.”

How has the operation changed you physically?
“It’s destroyed my body.”

If you wear a prosthesis are you experiencing any problems with this at the moment?
“Yes.”

If so, what kind of problems?
With fit?
“Yes, it has never fitted well.”

With weight?
“It is a bit heavy.”

With comfort?
“I’ve never really taken to it as it can be very uncomfortable.”

How satisfied are you with your prosthesis?
“I’m as satisfied as I’m ever going to be.”

**Do you have problems with clothes or underwear fittings?**

**If so what are they?**

“I do have some problems because it doesn’t fit well.”

Do you have any worries about being seen naked or topless?

“No, not at my age.”

**Has your husband or partner seen your scar?**

**If not, why not?**

“He left me soon after.”

**If yes, how has he reacted to your scar?**

Not applicable.

**What help could have been offered to your partner/husband at the time of your diagnosis and operation?**

“I don’t know, but he needed something.”

**What would he have gained from this?**

Not applicable.

**What was the worst thing for him to come to terms with?**

“The mastectomy.”

**Do you feel this is still the case?**

“Yes.”
Do you think your husband/partner is upset about you having lost part of your breast or losing your breast?

“He couldn’t cope with me not being whole, so he switched off from me totally.”

What is it that upsets him?

“If this terrible thing hadn’t happened I’m sure we would still be together.”

Does your husband/partner make any comment about your physical appearance because of the operation?

“Not any more.”

Would you say your husband/partner has been supportive since your operation? If so, how?

“No.”

Has anything changed in your relationship as a result of the operation?

“Like I said he left me.”

Has there been any significant change in the intimate nature of your relationship with your husband since the operation?

Not applicable.

Have you grieved for the loss of your breast/part of breast?

“Most definitely.”

Do you continue to be upset?

“Yes I do.”
If so, what is it that upsets you?
“Because it’s not there any more and because of what happened to me.”

Do you feel the operation has affected your sense of being feminine?
If so, how?
“Yes it has. I don’t feel like a woman anymore. I feel a bit of a freak.”

Do you think it has affected your sense of self?
If so, how?
“No not at all, I’m still the same.”

What were your feelings about radiotherapy?
“It felt like I’d beaten it, I’d recovered from the operation, it felt good, then the letter arrived asking me to come for radiotherapy, I thought, God, I’m not going to get better.”

Did you notice any effect upon your mood during this time?
If so can you tell me more about this?
“Yes I did, I felt a bit down at the time. You know kind of low in myself.”

Do you attend for regular check-ups with your Consultants?
“Yes, I do. I still have to go.”

How do you feel about them?
“I don’t like them because it reminds me I’m still ill, that I mat never be out of the woods.”

Do you feel you are sufficiently supported by the hospital now your treatment is over?
“They’re OK. The Cancer Support Group is better.”

**How might this be improved?**

“I don’t know.”

**What has been most helpful to you?**

“Outside of my family, the Cancer Support Group have been lovely. I attended here for quite a while after my operation, they were so good.”

And the least helpful?

“My husband leaving.”

THANK HER FOR HER TIME/MAKE AWARE OF COUNSELLOR SUPPORT
ANY OTHER COMMENTS/NOTES
STUDY TWO

Psychological Management of Anxiety and Stress in the Waiting Period before Major Vascular Surgery

First submitted in partial fulfilment of the MS c in Clinical Psychology

University of Surrey, 1992
Abstract

Anxiety affects patients from the first inklings of their problems, through diagnosis and the waiting period, to surgery, and recovery. Previous studies have concentrated on various interventions during the peri-operative period, whereas the pre-operative waiting period is brought within the present study's range. Patients awaiting major vascular surgery in Wolverhampton during 1992 were studied, and the effectiveness of an intervention group was measured. Aspects of anxiety-provoking situations included the response to diagnosis, information requirements, and problems experienced during waiting. The study found considerable levels of anxiety on diagnosis and throughout the waiting period, this latter being exacerbated by consultants' inaccurate estimates of surgery dates. Levels of anxiety were assessed using measures of state and trait anxiety, loci of control, and mood profiles, and comparisons were made between intervention and control groups, and between assessment and re-assessment. It is advocated that further work be undertaken on the rôle of the patient's family and on a screening procedure for optimal allocation of resources, and that continuous monitoring of patients throughout the waiting period be incorporated into standard patient care.
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Acknowledgements

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Note

This report has been compiled using the precepts of the American Psychological Association (American Psychological Association, 1983) as a guide to form and layout.

The right of Anita Helen Farrell to be identified as author of this work has been asserted by her in accordance with the Copyright, Designs and Patents Act 1988.
Introduction

This study of twenty-four patients awaiting major vascular surgery emerged out of an investigation into the effectiveness of group intervention on pre-operative anxiety.

Waiting list

Since the inception of the National Health Service (NHS), elective surgery has been preceded by a period of waiting. A waiting list for any surgery is easily created when one considers the multitude of problems of running the hospital, staffing and resource shortages. Indeed, recent measures such as the introduction of the Patient's Charter and the Waiting List Initiative have drawn the attention of providers and consumers alike to this aspect of care.

The low priority accorded to waiting and the lack of research on its effect on patients are indicated by the paucity of the literature on the subject. Frankel (1989) deems it unacceptable that patients should wait more than one year for non-urgent treatment or surgery. Williams (1968) draws attention to the suggestion that a surgeon may manipulate a waiting list, either as a status symbol, or as a political weapon to increase funding, or possibly to encourage patients to seek private treatment. Several authors report improvements in waiting time arising out of modest injections of funding aimed specifically at the reduction in waiting lists (see Sanderson, 1978; Mills and Heaton, 1991). Marber et al (1991) conclude that prolonged waiting for routine investigations and revascularisation may subject NHS patients to unnecessary risks, and to the necessity of re-assessment which thereby engenders further stress and longer waiting.
Nord (1990) highlights the psychological costs involved in waiting, and argues that cost-benefit analyses will aid the decision process and trim waiting lists in the most efficient manner. He mentions the individual's suffering, the deterioration of his physical condition, the psychological stress, the added pressures of healthcare consumption and the increased risk of permanent disability as the major psychological costs.

In identifying patients who deserve priority treatment, informal criteria are used by doctors and surgeons. Naylor et al (1990) attempted to formalise these criteria based on severity of symptoms, angiographic results and non-invasive tests, taking waiting time into account when assessing anxiety levels. Their study involved assessment for coronary revascularisation, but the criteria apply equally to other operations. However, Lim (1991) argues that the prevalence and the severity of such cases make it difficult to rank patients, and claims that the real issues raised by Marber et al (1991) have not been resolved. Consensus on criteria for unacceptable (dangerous) delay has, he argues, remained unresolved, as has the reducibility of NHS queues.

Given the inevitably finite (and therefore equally inevitably insufficient) resources available, we must address the optimal allocation to reduce patients' psychological stress during the waiting period. Herein, psychological stress is defined as the regular overloading of a person's capacity to tolerate physical, cognitive and emotional activity, precipitating changes related to exhaustion and defence (Nicholls, 1989). However, most research has concentrated on the period immediately preceding surgery, after the waiting-time stress has already been suffered by the patients. Christopherson and Pfeiffer (1980) argue for research into the timing of presurgical psychological intervention.
Traditionally, the assumption has been made that there will be weeks (if not months) to come to terms with impending surgery, and each individual's experiences during this waiting period must be taken into account, along with his expectation of the length of the waiting period. It is important to note that adjustment is also required of members of the patient's family, an aspect of patient management which has received but scant regard from previous researchers. Keitel et al (1990) have studied the problem, and they found very high levels of stress in spouses of patients undergoing surgery for cancer (indeed, the stress levels in spouses were greater than in the patients themselves); there are very few researchers to have looked beyond the patient.

Rakoczy (1977) examines the thoughts and feelings of patients in the waiting period before elective cardiac surgery. Her descriptive study highlights the problems faced by patients entering hospital for their planned operations. She attempts to draw a model of phases through which patients thoughts and feelings pass, as follows.

<table>
<thead>
<tr>
<th>Confrontation</th>
<th>face to face with the reality of impending surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-reflection</td>
<td>attempting to explain or justify the course of their problems and the personal losses engendered by these losses</td>
</tr>
<tr>
<td>Resolution</td>
<td>the meaning of surgery and resolving to go through with it</td>
</tr>
<tr>
<td>Countdown</td>
<td>the diminishing time prior to surgery is counted off in units</td>
</tr>
</tbody>
</table>

Table 1: Phases of patients' feelings

In her summary of findings, she shows the importance of allowing patients to express their feelings. She is able to show that if patients had passed successfully through the various phases of psychological preparation of
surgery, this tended to ensure a good outcome. She suggests that not all patients require a great deal of information in their immediate pre-operative period, and that such work may be done in the preceding weeks or months before surgery.

**Pre-operative anxiety**

Anxiety may be defined as an emotional response to a threatening situation, and it may be said that the threat of surgery and hospitalisation creates anxiety for most individuals. The various threats noted include possible physical disability, infliction of pain, or loss of life as the most obvious perceived stressors; however, one must not underestimate the need to cope with a new social situation in the hospital and the deprivation of freedom this entails.

It is well documented that patients with high levels of anxiety run a greater surgical risk than those with low anxiety levels. Williams *et al* (1972) argue that the need for higher levels of anaesthesia for anxious patients increases the risk of death during anaesthesia. Evidence also exists indicating that pre-operative anxiety is predictive of some aspects of post-operative recovery and its accompanying emotional state. Many studies have shown the link between pre-operative anxiety and length of hospital stay, levels of post-operative medication required, blood pressure, pulse rate and psychological adjustment. The literature tends to support such findings despite the inherent problems of research in assessing recovery from surgery and the subjective nature of the instruments used for assessment.

As early as 1958, Janis postulated a curvilinear relationship between pre-operative anxiety and post-operative emotional state. He found that patients who exhibited either abnormally high or low levels of anxiety prior to
surgery showed emotional disturbance following surgery. Later studies have found linear relationships between anxiety before and after surgery (Johnston et al, 1971). Clearly, it is arguable that it is important to allay patients' fears before surgery. This may be said to be all the more important for those undergoing life-threatening or major surgery.

Relaxation and pre-operative anxiety

One must pinpoint both the nature and the timing of an intervention to obtain the optimal result. Past research has concentrated exclusively on the few days immediately prior to surgery; many researchers have taken a cognitive behavioural approach (Kendall, 1983; Meichenbaum and Cameron, 1983). Ryan (1977) suggests that an appropriate time may be during the pre-admission period when patients attend the outpatients clinic. Johnston (1980) concludes that anxieties must be addressed well before admission to hospital.

In particular, relaxation training has been used both as a method of reducing anxiety and as a coping strategy for stressful medical procedures. Positive results have been obtained by Flaherty and Fitzpatrick (1978), who found that surgical patients reported less pain and distress, and requested less medication after being taught relaxation. Similarly, Aiken and Henricks (1971) report that cardiothoracic patients who had been trained in relaxation techniques were less likely to have post-surgical psychotic episodes than those who had not received such training.

In a recent study by Miller and Perry (1990), relaxation techniques were employed to help patients manage post-operative pain. Patients were taught relaxation techniques on the night before surgery. Relaxation for post-operative pain control is effective in reducing muscle tension and emotional stress, decreasing the autonomic responses of pain, tension and anxiety.
(McCaffery, 1980). This is just as important and relevant to patients with chronic conditions awaiting surgery. Fenn et al. (1986) also used relaxation in patients undergoing cardiac catheterisation and found the technique helpful in reducing respiratory rates. However, Pickett and Clum (1982) found cognitive distraction more effective than relaxation. Sensky (1989) identified the particularly useful aspects of cognitive therapy relating to chronic physical illness. The main task of the therapist is to help patients to acquire skills to examine their own thoughts. This, therefore, enables patients to resolve inaccurate attributions about themselves and their health.

Personal control is seen by Wallston et al. (1978) to be the key component of therapy. Pickett and Clum (1982) reviewed the evidence of locus of control and its interaction with treatment. Their findings indicate that brief interventions aimed at reducing state anxiety associated with surgery are effective, and that this warrants the inclusion of a measure of locus of control in studies of pre-operative anxiety.

**Coping style**

Andrew (1970) looked at coping styles, identifying 'avoiders' who were more likely to distance themselves from their own emotions, 'sensitisers' who felt in touch with their own feelings, and 'neutrals' who demonstrated no avoidance or sensitised coping style. This study revealed the risk of increasing stress by giving information to avoiders.

Later, Fox et al. (1989) attempted to distinguish between trait anxiety and coping style as predictors of pre-operative anxiety in dental patients. Their findings indicate that trait anxiety was the best predictor of pre-operative anxiety, but that a repressive coping style may be a confounding factor; this informs our choice of predictive measures in the present study. Cohen and
Lazarus (1973) found that some patients ('blunters') actively avoided seeking information about their impending surgery, whilst others ('sensitisers') actively sought out information.

Manyande and Salmon (1992) have made a preliminary attempt to separate anxiety and coping in a study of patients undergoing minor abdominal surgery. They report that anxiety was a good predictor of post-operative anxiety in the short term. This has implications for the formulation of an appropriate intervention.

Mechanic (1979, 1980, 1983) suggests that high monitors (who seek out threat-relevant information) and low-level blunters are more sensitive to internal bodily symptoms (which become heightened when the individual is under stress) than low monitors (who typically ignore threat-relevant information) or high-level blunters. Miller et al (1988), exploring individual differences in health-seeking behaviour and health status in a primary care population, found that high monitors have less personal control and more post-surgical physical and psychological problems. These researchers have produced parallel conclusions, Mechanic indicating that high monitors are more inclined to attend to their physical symptoms while Miller et al pointing out their demands for more tests, counselling and information. These attributes may help to target the scarce resource of psychological intervention on the people who will be more receptive to it.

By contrast, Mumford et al (1982) argue that there is no need to tailor therapy to patients' needs, but rather that an overall approach increases the overall expected 'gain' in a Benthamite fashion. The literature advocates and supports the many ways in which clinical psychology services can influence health, not only in primary health care, physical medicine and adjustment to illness but also in a broader sense in dealing with psychosocial problems. This is
particularly relevant to patients approaching a medical crisis because emotional factors may influence the course of the existing condition and recovery. Anderson (1987) argues that it may be harmful to give information without also teaching coping strategies which will increase the patient's belief in their own control. This marriage of information and compensation applies in equal measure to the waiting period, as long as it aids the 'work of worrying' (Janis, 1958) in an appropriate fashion.

**Group work**

Previous psychological interventions for pre-operative anxiety have concentrated on individual rather than group work with varying, but generally positive results. Emery (1981) is only one of many researchers to have reported the importance of learning coping skills such as relaxation, and of teaching primary healthcare in terms of diet, exercise and medical recommendations; this may be achieved within a group.

Self-help, and the importance of education on nutrition, lifestyle, and the prevention and control of health problems for those in declining health is discussed by Robinson (1981); Killilea (1976) identified the useful characteristics of self-help groups. The sharing of information and dissemination of knowledge, expertise and skills may be facilitated through group work, thus dispersing the social discredibility and stigmatisation of a shared problem (Goffman, 1963). The advantages of group therapy over individual therapy are

- economy of time and resources
- mutual support at times of stress
- enhancement of self-esteem
- facilitation of change in attitudes of group members
Markus et al (1989) highlight the educative nature of most groups and the likelihood that different approaches in varying combinations may be appropriate at different stages of illness.

**Health promotion**

The promotion of good health has received a great deal of attention, evidenced by the increasing demand for a healthy lifestyle. However, this demand has come from the healthy population to whom the promotion is addressed, leaving more vulnerable high-risk groups (such as vascular patients awaiting surgery) relatively unsupported. Hickey and Stilwell (1991) draw attention to this with reference to health promotion for older adults, and their view of health promotion as damage limitation obtains equally for other high-risk groups. Shopland and Brown (1987) relate a similar outcome with respect to smokers, where the concentration on preventing newcomers from entering the smoking population leaves little time for strategies other than damage limitation in helping long-term smokers. Biddle and Fox (1989) discuss the relationship between exercise and health psychology, and they suggest further investigation of interaction between social, environmental and biological factors.

The benefits of a nutritious diet, so well-known for healthy people, are in fact more important for those with disability or illness. Blankenholm et al (1990a, 1990b) concluded that protein and carbohydrates are preferred substitutes for fat in helping to reduce the risk of new lesions of the coronary arteries, and Simopoulos (1990) offers evidence that eating even very small amounts of fish decreases the likelihood of cardiovascular disease.

However, many people cite the longstanding entrenchment of poor eating habits as justification for their dietary inertia. Obesity is frequently a problem
amongst vascular patients and formulates a major risk factor for many age-related chronic conditions, so dietary intervention must constitute an important aspect of healthcare. Nonetheless, patients awaiting surgery receive little or no dietary advice. Nikolaus et al. (1991) argue that dietary information must be accompanied by motivatory encouragement. Such enthusiasm on the part of the healthcare professionals must, of course, be tempered with realistic expectations for change.

**Aims of study**

This study has two principal aims. The first is to investigate the problems and feelings experienced by people awaiting major vascular surgery, with particular reference to anxiety and stress, therefrom identifying the information found to be most useful by these people during the waiting period before admission for surgery. The second aim is to evaluate the effectiveness of group-based intervention for patients awaiting surgery, by comparing the patients who elected to join a group and those who did not. Specifically, it was hypothesised that subjects who had been involved in the group-based intervention would be found to be less anxious at the follow-up assessment than at the original.
Method

Subjects

The subjects included both male and female patients awaiting major vascular surgery, and were recruited from operating lists of two Consultant Surgeons at New Cross Hospital and the Royal Hospital, Wolverhampton. Owing to language difficulties, no subjects were taken from ethnic minority groups to be included in the study. Clearly, there are questions of anxiety and fears due to these special communicative problems which are deserving of investigation, but it is beyond the scope of this study to address this issue.

Of the 24 subjects in the study, there were 4 female and 20 male patients between the ages of 47 and 79 years (mean age 66 years), predominantly from the C2 socio-economic classification (MORI, 1989), and nineteen of whom were married. From the table below, it may be seen that the split between the two broad socio-economic groups ABC1 and C2DE is 41.7% to 58.3%. The remarkable coincidence that the national ABC1/C2DE split is identically 41.7% to 58.3% (Advertising Association, 1991) is a useful acknowledgement of the small sample's validity.

<table>
<thead>
<tr>
<th>Classification</th>
<th>No.</th>
<th>Percentage</th>
<th>Cumulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>B</td>
<td>1</td>
<td>4.2</td>
<td>4.2</td>
</tr>
<tr>
<td>C1</td>
<td>9</td>
<td>37.5</td>
<td>41.7</td>
</tr>
<tr>
<td>C2</td>
<td>11</td>
<td>45.8</td>
<td>87.5</td>
</tr>
<tr>
<td>D</td>
<td>3</td>
<td>12.5</td>
<td>100.0</td>
</tr>
<tr>
<td>E</td>
<td>0</td>
<td>0.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 2: Demographic distribution of subjects

The table below shows that the majority of the subjects were no longer employed either through ill health or having attained retirement age.
### Table 3: Employment status of subjects

<table>
<thead>
<tr>
<th>Employment status</th>
<th>No of subjects</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>full time</td>
<td>3</td>
<td>12.5</td>
</tr>
<tr>
<td>part time</td>
<td>1</td>
<td>4.2</td>
</tr>
<tr>
<td>unemployed</td>
<td>2</td>
<td>8.3</td>
</tr>
<tr>
<td>retired</td>
<td>18</td>
<td>75.0</td>
</tr>
</tbody>
</table>

Of the 32 patients originally contacted by a letter from the researcher (16 from each surgeon), 24 (13 and 11 from the two surgeons) agreed to take part in the study: a 75% rate of agreement. These 24 were interviewed at home by the researcher: at this point, the patients’ consent to proceed was obtained (all 24 consented). Fourteen of the original sample indicated their willingness to join a group; from these, an intervention group of seven was formed. The group, led by the researcher, met once; all the initial sample were then re-assessed.

The table below shows the categories of vascular surgery and the numbers of subjects for each category.

### Table 4: Operative categories

<table>
<thead>
<tr>
<th>Category</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aorto-femoral by-pass graft</td>
<td>7</td>
</tr>
<tr>
<td>Carotid surgery</td>
<td>5</td>
</tr>
<tr>
<td>Femoral by-pass graft</td>
<td>4</td>
</tr>
<tr>
<td>Abdominal aortic aneurysm</td>
<td>2</td>
</tr>
<tr>
<td>Aorto-iliac graft</td>
<td>2</td>
</tr>
<tr>
<td>Brachial aortic aneurysm</td>
<td>1</td>
</tr>
<tr>
<td>Innominate arterial surgery</td>
<td>1</td>
</tr>
</tbody>
</table>

All patients had been on the waiting list for their surgery for a minimum period of 3 months, some patients having waited up to 24 months. The mean waiting period for surgery was 8.5 months.
Study Design

Taking early February as the base time, the sequence of events in the study is measured in weeks.

*Initial group membership* Week 0

<table>
<thead>
<tr>
<th>Control group</th>
<th>Intervention group</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 patients</td>
<td>12 patients</td>
</tr>
</tbody>
</table>

*Pre-intervention measures (all subjects)* Weeks 1-3

- Pre-operative Anxiety Questionnaire
- Multidimensional Health Locus of Control
- Profile of Mood States–Bipolar
- State Trait Anxiety

*(Single) Group meeting (intervention group only)* Week 8

*Post-intervention measures (all subjects)* Weeks 10-12

- State Trait Anxiety
- Profile of Mood States–Bipolar

*Final group membership* Week 12

<table>
<thead>
<tr>
<th>Control group</th>
<th>Intervention group</th>
<th>No-show group</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 still awaiting surgery, 2 completed surgery, 3 too upset to be interviewed again</td>
<td>7 still awaiting surgery plus 2 wives (uninvited)</td>
<td>2 too ill to attend group, 2 completed surgery, 1 unable to attend group</td>
</tr>
</tbody>
</table>

For the purposes of further analyses, the fourteen patients who were still awaiting surgery were used to assess the effects of intervention group membership and operative history.
Instruments

Multidimensional Health Locus of Control

This questionnaire (Wallston et al, 1978) measures internal and external loci of control, the latter being subdivided into control by specific and random others. The subject is asked to rate on a scale of 'strongly disagree' (1) to 'strongly agree' (6) their own responses to questions related to health and their perceptions of control over their own health.

The multidimensional health locus of control scale has been used widely in the research of pre-operative anxiety. This would therefore offer the opportunity for comparison of this group of patients to those in previous studies. A copy of the questionnaire is enclosed at Appendix 1.

The Profile of Mood States - Bipolar Form

This inventory (Lorr and McNair, 1984) measures six bipolar subjective mood states, each defined by a scale which comprises a positive/negative pair of contrasting adjectives as in the table below.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>composed ↔ anxious</td>
</tr>
<tr>
<td>B</td>
<td>agreeable ↔ hostile</td>
</tr>
<tr>
<td>C</td>
<td>elated ↔ depressed</td>
</tr>
<tr>
<td>D</td>
<td>confident ↔ unsure</td>
</tr>
<tr>
<td>E</td>
<td>energetic ↔ tired</td>
</tr>
<tr>
<td>F</td>
<td>clear-headed ↔ confused</td>
</tr>
</tbody>
</table>

Table 5: Profile of Mood State dichotomies

A copy of the questionnaire is enclosed at Appendix 2.
The subject is asked to rate his/her feelings 'during the last week, including today'. The response ranges from 'much unlike this' (0) to 'much like this' (3). The scale score (of positivity) is the difference between the sums of the positive and negative items, adjusted by adding 18 to give a score between 0 and 36. Reliability studies have indicated a high level of consistency using those adjectives and good test-retest reliability. Research has also supported the construct and criterion validity of the inventory which, given its wide use, invites comparison with other studies.

*The State-Trait Anxiety Inventory*

This inventory (Spielberger *et al.*, 1970) measures two distinct anxiety concepts: state anxiety (A-State) and trait anxiety (A-Trait). The essential qualities evaluated by the A-State scale involve feelings of tension, nervousness, worry and apprehension. State anxiety may be conceptualised as a transitory emotional state or condition characterised by subjective, consciously perceived feelings of tension and apprehension, and which may fluctuate over time. The A-Trait scale evaluates the relatively stable individual qualities and differences in disposition to anxiety in response to stressful situations, and can thus be compared to the amount of state anxiety present. In general, it is expected that those scoring highly in trait anxiety will also exhibit higher levels of state anxiety because of their underlying predisposition.

Each scale of STAI consists of 20 statements. The trait scale asks individuals to describe their general feelings, whereas the state scale asks individuals to indicate how they feel at that particular moment in time. The choices of response for each scale range from 'very much' (1) to 'not at all' (4). Successive questions are scored with randomly varying 'directions' to overcome any bias
in the responses. The inventory has been widely used and evaluated by researchers, and compares well with other measures of anxiety. A copy of the questionnaire is enclosed at Appendix 3.

Pre-operative anxiety questionnaire

This instrument was developed by the present researcher, taking particular note of the results of the questionnaires of Burton and Parker (1988), and looks specifically at the fears, worries and concerns generated by a forthcoming admission into hospital and anticipated operation, using open and closed questions.

The issues addressed may be summarised into the following categories.

• initial reaction to the need for surgery
• ability to cope with their feelings
• ability to cope with daily life whilst waiting for surgery
• ability to cope with the wait
• past operative history
• fears about pain
• fears about anaesthesia
• fears about waking during surgery
• fears about communication problems

The responses to each question were recorded as fully as possible, coded and scored. A copy of the questionnaire is enclosed at Appendix 4.

Procedure

Each patient was recruited by a letter (a copy of which is enclosed at Appendix 5) which explained the basic tenets of the study and offered an
interview in the patient's own home. All initial interviews were conducted in February 1992.

A more detailed explanation was offered at the initial interview with the patient, and the patient was asked to sign a consent form (a copy of which is enclosed at Appendix 6) agreeing to partake in the research. Each patient was assured of the confidentiality of the data. On obtaining the patient's agreement, a letter was sent to each patient's general practitioner to inform them of the patient's agreement to participate in the study (a copy of which is enclosed at Appendix 7).

Once the formal consent had been signed, the subjects were asked to complete three standardised psychological instruments: POMS–Bipolar, MLCS and STAI. The semi-structured questionnaire was then presented to the subject, with the aim of eliciting pre-operative concerns about pain or anaesthesia, and any worries patients may have about admission to hospital. This included details of past operations and comments upon treatment received thus far. Finally, the demographic data were collected. All measures and questionnaires were administered by reading aloud to the subjects, to compensate for difficulties in communication and comprehension.

Because of the small sample size, it was not possible to make a random allocation of patients to the intervention and control groups; indeed, there was no prior knowledge of the level of enthusiasm amongst the patients for the idea of an intervention group. Each subject was therefore invited to participate in such a group, run by the researcher and addressing the worries and concerns they had raised during the initial interview. Of the 24 subjects interviewed, 14 stated that they would like to attend a group. Two of these were excluded from group participation on medical grounds, two were unable to attend owing to other hospital commitments, and three were
admitted for their operations prior to the meeting of the group. Of the seven who attended, two male subjects were accompanied by their wives, making a total of 9 people who attended the group. Those who declined the offer of a group meeting formed a non-intervention control group. This meeting took place on 2nd April 1992 for a period of two and a half hours, the timetable of which is given in the table below.

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1400</td>
<td>Introduction</td>
</tr>
<tr>
<td></td>
<td>Talk by dietician</td>
</tr>
<tr>
<td>1445</td>
<td>Break</td>
</tr>
<tr>
<td></td>
<td>Informal question time</td>
</tr>
<tr>
<td>1515</td>
<td>Biological explanation of anxiety by researcher</td>
</tr>
<tr>
<td></td>
<td>Cognitive triad</td>
</tr>
<tr>
<td>1545</td>
<td>Breathing exercises</td>
</tr>
<tr>
<td>1600</td>
<td>Relaxation training</td>
</tr>
<tr>
<td>1625</td>
<td>Résumé, feedback</td>
</tr>
<tr>
<td>1630</td>
<td>Close</td>
</tr>
</tbody>
</table>

Table 6: Timetable of group meeting

Two weeks later all subjects were interviewed again, and data were collected on the POMS-Bipolar and STAI instruments. Equal time was allowed for each subject (whether in the intervention or control group) to express their feelings following the administration of the questionnaires. The intervention group's use of the information and training given during the group session was explored as fully as possible.
Results

Operative history

The table below describes the operative history of the sample, giving the mean number of operations per subject in three time intervals. A copy of the data form used to collect demographic and other such data is enclosed at Appendix 8.

<table>
<thead>
<tr>
<th>Time elapsed</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>less than 1 year</td>
<td>0.67</td>
</tr>
<tr>
<td>1 to 5 years</td>
<td>0.42</td>
</tr>
<tr>
<td>more than 5 years</td>
<td>1.54</td>
</tr>
<tr>
<td>Total</td>
<td>2.63</td>
</tr>
</tbody>
</table>

Table 7: Operative history of subjects

Of the twenty-four subjects, four had never been operated upon before the current operation. Of the twenty subjects who had past experience of surgery, eighteen had undergone previous operations within the health area of Wolverhampton, either at New Cross or at the Royal Hospital. Of the five who were unmarried, only one person wished to join a group, while the majority (twelve in number) of those who were married viewed the idea of a group more favourably.

The seven members of the intervention group tended to be slightly younger than the seven in the control group who were still awaiting surgery (the mean ages were 62.3 and 66.4 years respectively), though this difference was not statistically significant. A significant difference in 'waiting time' was found (control 15.0 months, intervention 7.9 months): this may be a confounding factor in assessing differences between the two groups. The F-test for a difference in variance between the two groups proved to be significant, with
an F-value of 15.57 which, on the $F_{7,7}$ distribution, gives a two-tailed significance probability of 0.004. The t-test for a difference in the mean number of previous operations was therefore undertaken with the assumption of separate variances. This test gave a statistic of 2.88 which, on the $t$ distribution with a nominal 6.77 degrees of freedom, gives a two-tailed significance probability of 0.050.

There was a significant difference (at the 5% level) between the two sets regarding operative history: the intervention group members had undergone an average of 1.4 operations, while the control group's mean was 4.4 previous operations. The F-test for a difference in variance between the two groups proved not to be significant, with an F-value of 3.68 which, on the $F_{7,7}$ distribution, gives a two-tailed significance probability of 0.138. The t-test for a difference in the mean number of previous operations was therefore undertaken with the assumption of equal (pooled) variances. This test gave a statistic of 2.88 which, on the $t_{12}$ distribution, gives a two-tailed significance probability of 0.014.

The full table for these three tests appears on page 2 of Appendix 9.

No significant differences in pre-operative anxiety could be reported between those undergoing their first operation and those who had previous history of surgery.

**Feelings experienced on diagnosis**

The tables below show the feelings experienced by the subjects on diagnosis, their responses to the need for surgery, and their methods of dealing with their feelings. The preponderance of shock and anxiety in the first two tables is noteworthy.
Feeling | No.
---|---
Shock | 12
Resignation | 7
Relief | 5

Table 8: Patients' responses on diagnosis

Response | No.
---|---
Anxiety | 15
Acceptance | 6
Anger | 3

Table 9: Patients' responses to the need for surgery

Method | No.
---|---
Apathy | 3
Acceptance | 6
Rumination | 6
Distractive blocking | 9

Table 10: Patients' ways of dealing with feelings

**Information requested by subjects**

At interview, all subjects requested more information about maintaining optimum health during the waiting period; the distribution of topics is given below.

| Topic | Count |
---|---|
diet | 18
relaxation | 14
contact with hospital during waiting period | 12
exercise | 5
smoking | 4

Table 11: Information topics
Problems experienced during waiting period

The initial interview made clear the difficulties which all subjects encounter during the waiting period: ten out of the twenty-four felt dissatisfied with the wait itself. The major problems reported by the subjects are laid out in the table below.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>stress due to uncertainty of surgery date</td>
<td>24</td>
</tr>
<tr>
<td>discrepancy between advised and actual waiting time</td>
<td>22</td>
</tr>
<tr>
<td>distress and uncertainty about the future</td>
<td>18</td>
</tr>
<tr>
<td>apprehension about notification of forthcoming surgery</td>
<td>16</td>
</tr>
<tr>
<td>stasis and isolation from hospital during waiting period</td>
<td>13</td>
</tr>
<tr>
<td>fear of physical deterioration</td>
<td>8</td>
</tr>
<tr>
<td>reduced quality of life and increasing dependency</td>
<td>8</td>
</tr>
</tbody>
</table>

Table 12: Patients' problems during waiting period

Pre-operative anxiety

The pre-operative anxiety questionnaire showed that fifteen subjects reported some level of worry, and that eight reported some degree of depression. Although all subjects reported an expectation of communication problems with nursing staff, only four were concerned about post-operative pain and three worried that they might be unable to communicate their pain to staff. Most subjects were unworried about the effects of anaesthesia, being unconscious, not recovering from the anaesthetic, surgical apparel worn by staff or vomiting following the surgery as a result of administered anaesthesia. However, three subjects worried about injections and five feared the anaesthetic more than the operation itself. Nine subjects requested information about pain control, exactly the same number who asked for information about anaesthesia. The table below itemises the worst fears that subjects have about this kind of surgery.
Table 13: Patients’ fears about surgery

Fourteen patients were satisfied with their treatment, the other ten citing the wait as a major source of dissatisfaction. On performing a crosstabulation between the level of worry about surgical complications and receptivity to membership of an intervention group, the Pearson $\chi^2$ statistic of 7.12 showed a significant dependency between the two variables, the statistic giving a significance probability on the $\chi^2$ distribution of 0.028. On inspection of the table (which may be found on page 4 of Appendix 9), it may be seen that those receptive to the idea of group membership are more likely to have fewer worries about surgical complications than those who were unreceptive, though it must be noted that the small size of the sample gives rise to the usual problems regarding expected cell frequencies.

Overview of measures

The measures of anxiety and mood had the following sample characteristics.

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical trauma (loss of limb)</td>
<td>4</td>
</tr>
<tr>
<td>Worry about survival of operation</td>
<td>4</td>
</tr>
<tr>
<td>Embarrassment about bedpan use</td>
<td>4</td>
</tr>
<tr>
<td>Operation itself</td>
<td>3</td>
</tr>
<tr>
<td>Damage to mental functioning</td>
<td>2</td>
</tr>
<tr>
<td>Cancellation of operation</td>
<td>2</td>
</tr>
<tr>
<td>Being a nuisance to staff</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 14: Sample characteristics of measures
The measures were investigated for inter-relationships using the standard Pearson correlation. The analysis showed up significant correlations between the two PMS scores, between the first trait anxiety measure and the two anxiety measures at re-assessment, and between the locus of control measures for the two 'others' categories. In addition, the (negative) correlations between the re-assessment state anxiety measure and the two PMS measures, and between trait anxiety measures (at both time-points) and the re-assessment PMS score were significantly high. The actual correlations, all based on the sixteen cases for whom full data were available, are given in the table overleaf.

**Differences between groups**

The groups did not differ on the measure of locus of control, state-trait anxiety or on the profile of mood status, nor were there any differences over time in the two State-Trait Anxiety scores. Though no significant difference in Profile of Mood State scores was found on the first assessment, the second and third scores (agreeable/hostile and elated/depressed respectively) showed a tendency towards higher scoring by the intervention group following the intervention, though this difference was not statistically significant at the 5% level. At the re-assessment, the only discernible difference in the scores of the control group was found in the second of the scales; once again, this increase in positivity was only significant at the 10% level.

No significant differences could be found before the intervention between the intervention group members and the subset of the controls who were still awaiting surgery.

Full details of the tests may be found on pages 6 to 12 of Appendix 9.
<table>
<thead>
<tr>
<th></th>
<th>State Post</th>
<th>Trait Pre</th>
<th>Trait Post</th>
<th>Internal</th>
<th>Powerful</th>
<th>Chance</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Pre</td>
<td>0.2605</td>
<td>0.2322</td>
<td>0.0784</td>
<td>0.0683</td>
<td>-0.0838</td>
<td>-0.1157</td>
</tr>
<tr>
<td></td>
<td>p=0.165</td>
<td>p=0.193</td>
<td>p=0.387</td>
<td>p=0.401</td>
<td>p=0.379</td>
<td>p=0.335</td>
</tr>
<tr>
<td>State Post</td>
<td>0.4510</td>
<td>0.2569</td>
<td>0.3787</td>
<td>0.0908</td>
<td>0.2407</td>
<td></td>
</tr>
<tr>
<td></td>
<td>p=0.040</td>
<td>p=0.168</td>
<td>p=0.074</td>
<td>p=0.369</td>
<td>p=0.185</td>
<td></td>
</tr>
<tr>
<td>Trait Pre</td>
<td>0.6569</td>
<td>0.1435</td>
<td>0.0209</td>
<td>0.0092</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>p=0.003</td>
<td>p=0.298</td>
<td>p=0.469</td>
<td>p=0.486</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trait Post</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.0129</td>
<td>-0.1950</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>p=0.481</td>
<td>p=0.1244</td>
</tr>
<tr>
<td>Internal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.3581</td>
<td>0.2868</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>p=0.087</td>
<td>p=0.141</td>
</tr>
<tr>
<td>Powerful</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.5819</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>p=0.009</td>
</tr>
</tbody>
</table>

Table 15: Matrix of correlations of measures
Differences before and after group intervention

The comparison of the interviews before and after the group meeting showed that all subjects who attended the group found the group useful and interesting. Six out of the seven patients (and the two spouses who attended the group) reported that they had previously been unaware of their own poor diet and lifestyle and had never before made the links between physical and psychological well-being. All members had adapted their diet following the group, with some reporting some weight loss as a result. Of the two members who had smoked at the time of the group, one reported having given up completely, the other reported finding it difficult to do so but would like to seek further help. The advice on alcohol, although well received, was difficult to assess, because no members reported having an alcohol-related problem. Although the question of exercise was raised at the group meeting, the overriding need for individually tailored exercise régimes precluded any active suggestions.

The group had been given a biological explanation of anxiety, and of the link between behaviour, emotions and ways of thinking, and all members reported finding these explanations simple and easy to understand. Techniques of breathing and relaxation were also taught, and each subject reported using these techniques regularly.

All group members reported that they had derived some benefit from their attendance, and that these benefits could be increased and consolidated by the continuation of the group and the incorporation of people who had already undergone similar surgery. The mutual support of others awaiting the same surgery was very important to the group members.
Methodological issues

Any discussion of the results should be made with reservations concerning the limitations of the interviewing instruments which were not specifically designed to address the psychological consequences of waiting for major vascular surgery. Since the sample was drawn from a population over whose entry into the system the researcher had no control, the sample size was unknown at the start of the project. In the event, there were fewer patients than originally envisaged, and consequently there was no opportunity in the experimental design to control for the effect of attention.

Due to the nature of the sample, subjects were not allocated at random between the intervention and control groups, but rather were asked to choose whether or not they wished to attend a group. There were slight differences between the intervention group members and the control group members: subjects opting to join the group were slightly younger, less concerned about complications during surgery and had undergone fewer operations. The waiting period was, however, significantly longer for members of the control group than for those in the intervention group. Nonetheless, no significant differences were found between the groups on standardised measures prior to the intervention.

Findings

The present study has been conducted to identify the problems experienced by patients awaiting major vascular surgery, and to attempt to address such problems using a group-based intervention. The progress of those who
elected to join the group session has been compared with that of the members of the control group who elected not to join the group session, using such measures as mood state and anxiety levels.

**Problems experienced during waiting period**

Almost half of the patients in the present study found the waiting period a particularly difficult time. Three patients are of particular importance in this respect: all coming from the control group, they refused to be interviewed on a second occasion, and were very upset that their case for earlier surgery could not be forwarded in any way by participation in the study. These three patients reported that they were upset by the wait for surgery, that they feared death whilst awaiting surgery, and that they held out little hope for their future. This bleak outlook demonstrates with vivid clarity the levels of distress caused by the wait for surgery.

Those subjects who were interviewed reported worrying about deterioration of physical functioning, postponement of the date of surgery for whatever reason, and the difficulty found in planning ahead; the more able subjects were distressed by others' misconceptions of their being more healthy than was the case. Uncertainty in the scheduled date of surgery caused a vacuum in the lives of some patients, and intervention may provide much support to these people.

The stress which was being experienced by families became apparent during the interviews with the patients at home: this is in keeping with the findings of Keitel *et al* (1990). This observation, which was not pursued by the present study, merits further research.

Stress is induced in already vulnerable people when there is a discrepancy between advised and actual waiting time, and by the isolation from the
hospital staff and consultant surgeon during the period of limbo, when patients have too much time in which to ruminate about the forthcoming operation. Subjects were ambivalent to the notification of admission for surgery, scanning their mail each day for news, whilst simultaneously dreading the event should news arrive.

Overall, the current political climate's attachment of great importance to waiting lists should indicate the need for further research into patients' states during the waiting period: support is here given to Mills and Heaton (1991), who stress the importance of the reduction of waiting lists for major surgical patients, and point out that improvements are possible given the provision of funding.

**Group-based intervention**

The subjects who attended the intervention group meeting all derived benefit and found it interesting. The mutual support and identification with others in similar situations which the group engendered recalls the work of Goffman (1963). The continuation of the group, as requested by many of the subjects, could have led to a self-help group which, as Robinson (1981) points out, may facilitate the primary healthcare education of those in declining health. Meetings with past patients were also requested, and much further research is possible in this area. As Ryan (1977) suggested, the waiting period may be the ideal time for such a group to operate.

**Provision of information during the waiting period**

This aim of the study has been achieved, paralleling the work of Hickey and Stilwell (1991) with older adults. Requests for information on health and physical wellbeing came from the subjects in the present study just as from the older adults, and this may reflect a much more general need with other
The present study brought forth requests for information principally in the areas of diet, stress management and alcohol/smoking considerations.

The dietary changes which may benefit healthy people are even more important in those with a disability or illness (Blankenholm et al., 1990, Simopoulos, 1990). The short time between the group meeting and the second interview has precluded any significant insight into the effectiveness of the advice on diet and smoking, although there seemed to be positive steps in both of these areas; equally, no corroboration was possible with the work of Nikolaus et al (1991) and Shopland and Brown (1987), who suggest that information is not enough, and that encouragement and damage limitation are also necessary. Indeed, the findings support the work of Biddle and Fox (1989) in advocating that further investigation is required of the interaction between social, environmental and biological factors which may reveal the core relationship between predisposition for obesity, smoking and disease.

Relaxation training has proved to be a positive preparation for surgery (Janis, 1958), but it is disappointing that the only discernible improvement trends in the current study were the increases in composure, confidence and clear-headedness which were detected.

**Comparison between groups**

The principal difference in the management of the two groups was, of course, the psychological intervention. The time constraints of the study period made it impracticable to hold more than a single group meeting for the intervention group. Clearly, any effect of the group would have been easier to verify had more such meetings taken place. Equally, the small sample size makes the detection of statistically significant differences all the more difficult. However, the tendencies shown by comparing the two groups illustrate
where useful work may be concentrated in the future, and the conclusions made from the results of the comparative studies are presented in this light.

The differences in the PMS scores indicate the likelihood that there are differences between the intervention and control groups. The intervention group's usefulness (as reported by the subjects) in educating people in poor or declining health about diet, lifestyle and the prevention and control of health problems echoes the findings of Robinson (1981). Equally, the present study points in the same direction as Goffman (1963), who proposed that the sharing of the problems would help to reduce social discredibility and stigmatisation through the exchange of information, with the added attraction of economy of time and resources. Patients' needs differ over time, in different combinations of elements, and, of course, they differ from one patient to another (Markus et al, 1989). The present study evinced a wide disparity in the waiting times of patients in the intervention and control groups: this may indicate a greater receptivity to such interventions in the period immediately following diagnosis. This change of receptivity may constitute one facet of research into optimal timing of intervention, which has been recognised as an important subject for research (Ryan, 1977). The present study echoes Johnston (1980) in stressing the need for anxiety to be addressed long before admission to hospital, and advocates relaxation education as a particular benefit.

The present study has been unable to investigate links between intervention group membership and a general propensity to seek information (Cohen and Lazarus, 1973), and further research is needed to lessen the chance of pressing information on 'avoiders' (Andrew, 1970). The differences in demography, operative history and waiting time between the groups (see page 20) may also be linked, and further research is needed in order that resources may be targeted optimally. It is also important to follow up the work by Miller et al

**Subjects' thoughts and feelings**

The present study highlights the thoughts and feelings of people awaiting major surgery and illuminates the stress experienced following diagnosis of the need for surgery. Patients who appreciated the probability of forthcoming surgery appeared less shocked and more resigned than those subjects who were taken unawares by the news.

The feelings of the subjects in this study were directed towards the long waiting period. Three patients reported anger, disillusionment with a longer than anticipated waiting time; apathy, rumination and distractive blocking were present in others. Clearly, the work of worry (Janis, 1958) starts at the time of diagnosis and is mood-dependent. Worry is lessened if the inevitability of surgery is appreciated and patients who have come to such an appreciation may well be those who would need less information in the immediate pre-operative period (Rakoczy, 1977). This relationship merits further investigation. In addition, this study underpins Rakoczy's support for work during the waiting period to identify the similarities and differences in the psychological stress of patients awaiting different types of surgery.

**Pre-operative anxiety**

In the past, researchers have concentrated on studying levels of anxiety in patients during the period immediately before admission for surgery. During the interviews, the patients in the present study indicated that they were anxious about certain aspects of their condition throughout the waiting period. This suggests that the study of pre-operative anxiety should be extended to cover a much longer period than existing research has addressed.
The subjects of this study were, in the main, given anticipated dates for surgery which turned out to be wildly optimistic. The patients reported that the subsequent failure to honour the anticipated dates, and the resultant uncertainty over the actual dates, generated much anxiety and ill-will. This gives weight to the need to revise the traditional view of the waiting period as a time to come to terms with the impending surgery.

The diminution of anxiety levels reported by the intervention group members following the meeting indicates the potential benefit of teaching relaxation at that time. However, the data obtainable from this study cannot make clear whether the positive indications of change are directly attributable to the patients' having been taught relaxation techniques. Further work must be undertaken to refine the intervention in such a way that the true worth of relaxation may be assessed.

Most other studies have timed their intervention immediately before surgery when the patient is in a high state of distress or anxiety, and when there is little or no opportunity to derive benefit from the relaxation during the pre-operative period. Earlier teaching may allow patients to reap such benefits for a longer period, and the retention of the diminished anxiety levels throughout the waiting period may be an appropriate subject for future study. It is argued here that practice and consolidation are the keys to effective relaxation, and this may be a valuable use of the waiting period.

The present study combines relaxation with simple behavioural therapy to promote personal control. Although no differences could be found in locus of control in either the intervention or control groups, it is felt that personal control is an important aspect of coping. This must be enhanced in patients who perceive that they are becoming more dependent on others as their health deteriorates.
Fifteen out of the twenty-four subjects had worries, and this study has identified their sources. Reliable measures of anxiety about pain and anaesthesia cannot be made; however, information packs which explain the facts of surgery may be of benefit to some patients, and this merits further research. A few patients reported considerable psychological distress in particular areas, such as needle phobia. Early screening for such problems would be of great benefit to sufferers in reducing their stress throughout the waiting period. It is argued here that such screening may be highly cost-effective. The operation, as one might expect, was the principal source of fear; patients and families alike seem generally unprepared for the experience of post-surgical intensive care. Further research is needed to evaluate preparation strategies aimed at reducing anxieties about the physical measures necessary following surgery of this nature. Once again, there are no studies which may be used as comparisons with the present study.
The patients in this study reported being anxious at the time of their diagnosis and throughout the waiting period, and that further stress is caused by the lack of concordance between the actual date of surgery and the date given by the consultant, which latter is often wildly optimistic. There are indications (which may only be confirmed by further work) that membership of a guided mutual support group may be useful, at least for certain patients.

The current national initiatives to reduce waiting lists will, if successful, have a parallel effect of reducing the levels of pre-operative anxiety (with a concomitant reduction in stress-related complications in these patients). Information provision on the stages from diagnosis to recovery would have similar effects, and could be co-ordinated nationally with additional local information as necessary. The targeting of appropriate resources on patients who will derive the greatest benefit will be aided by a psychological screening process carried out at the earliest possible stage, and by monitoring all patients (both physically and psychologically) throughout the waiting period.

Further research is needed to establish the optimal strategy for group intervention and to compare this with individual therapy. This may be linked with much-needed study of the rôles of family and other supporters in the patient's management and preparation for surgery. The effectiveness of inclusion of others in patients' groups must be assessed, as must the long-term effects of group membership.


Appendix 1

Multidimensional Health Locus of Control Questionnaire
**Multidimensional Health Locus of Control Scale**

Please tell us whether you agree or disagree with these statements. Please ring the number that best describes your opinion.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Slightly Disagree</th>
<th>Slightly Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

I = Internal  
P = Powerful Others  
C = Chance

1. If I get sick, it is my own behaviour which determines how soon I get well again.

2. No matter what I do, if I am going to get sick, I will get sick.

3. Having regular contact with my physician is the best way for me to avoid illness.

4. Most things that affect my health happen to me by accident.

5. Whenever I don't feel well, I should consult a medically trained professional.

6. I am in control of my health.

7. My family has a lot to do with me becoming sick or staying healthy.

8. When I get sick I am to blame.

9. Luck plays a big part in determining how soon I will recover from an illness.

0. Health professionals control my health.

1. My good health is largely a matter of good fortune.

2. The main thing which affects my health is what I myself do.

3. If I take care of myself, I can avoid illness.

4. When I recover from an illness, it's usually because other people (for example, doctors, nurses, family, friends) have been taking good care of me.
15. No matter what I do, I'm likely to get sick.

16. If it's meant to be, I will stay healthy.

17. If I take the right actions, I can stay healthy.

18. Regarding my health, I can only do what my doctor tells me to do.

<table>
<thead>
<tr>
<th></th>
<th>strongly disagree</th>
<th>somewhat disagree</th>
<th>slightly disagree</th>
<th>slightly agree</th>
<th>somewhat agree</th>
<th>strongly agree</th>
</tr>
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<td>15</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

Total T
Total P
Total C
Profile of Mood State — Bipolar Questionnaire
Appendix 3

State-Trait Anxiety Questionnaire
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Appendix 4

Pre-operative Anxiety Questionnaire
Initial Letter to all Patients
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Appendix 6

Research Consent Form
To the Patient

The researcher named on this form is here to help you. You may ask any questions and seek further information. Studying the type of service given to patients is essential to the continuation of the health service and improving the quality of care. By taking part in this study, you may provide an important opportunity to benefit the service provided to patients.

You may refuse to be involved in this study without this adversely affecting your care and treatment in any way.

There will be stringent precautions to preserve confidentiality, and your name cannot be linked to your responses by anyone apart from the researchers.

Researcher

I confirm that I have explained the tasks involved in participating in this study in terms that the patient can understand, and the patient's right to refuse to participate in the study.

Signature ........................................................... Date ...................................
Name of researcher ...............................................................................................
Job title of researcher ...............................................................................................

Patient

Please make sure you have read this form carefully.

If there is anything you do not understand about the explanation, or if you want more information, you should ask the researcher who has explained about the study.

When you are clear about the study, and you have checked that all the information below is correct, please sign the form.

Surname ............................................................................................................
Other names ............................................................................................................
Date of Birth ............................................................................................................
Sex .........................................................................................................................
Hospital .................................................................................................................
Patient Number ...........................................................................................................
Signature ........................................................... Date ...................................
Letter to General Practitioner
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Appendix 8

Demographic Data Form
To the Patient

Thank you for agreeing to take part in the study. You will be given a few simple survey forms to fill in between now and some weeks after your discharge from hospital. They should not take long to complete, and the information which you give us will help us to improve the service to patients.

Firstly, we should like to know a little bit about you, and so it would help us if you could answer the following questions.

| Hospital | ........................................ |
| Patient Number | ........................................ |
| Surname | ........................................ |
| Other names | ........................................ |
| Date of Birth | ........................................ |
| Sex | ........................................ |
| Marital status | ........................................ |

Please answer the following questions about yourself and, if you have ever had one, your partner.

<table>
<thead>
<tr>
<th>Are you</th>
<th>self</th>
<th>partner</th>
</tr>
</thead>
<tbody>
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<td>□</td>
<td>□</td>
</tr>
<tr>
<td>in part-time work</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>unemployed</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>retired</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

What is/was your occupation?

........................................  ........................................
Appendix 9

Statistical Analyses
MATERIAL REDACTED AT REQUEST OF UNIVERSITY