# BREAST CANCER, POVERTY AND MENTAL HEALTH: EMOTIONAL RESPONSE TO THE DISEASE IN WOMEN FROM POPULAR CLASSES[1]

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*This study aimed to analyze the emotional response of a low-income group of women to the breast cancer. The sample was composed by 15 patients from a mastectomized women's support entity. Data were collected through individual face-to-face semi-structured interview. The results were appraised according to a classification system that postulates the existence of four categories mutually excluding: denial, stoicism, affliction and confrontation. The results obtained indicate that stoicism was the more frequent emotional response in the evaluated group. The scientific literature shows that stoicism can contribute to the temporary reduction of stress, but it gradually leads to a uselessness feeling which tends to make difficult the psychosocial adjustment to the disease and its treatment.*

*DESCRIPTORS: breast neoplasms; poverty; mental health; psychological adaptation*

## CÁNCER DE MAMA, POBREZA Y SALUD MENTAL: RESPUESTA EMOCIONAL A LA ENFERMEDAD EN MUJERES DE CAMADAS POPULARES

*El presente trabajo tiene como objetivo analizar las reacciones emocionales al cáncer de mama en un grupo de mujeres de clases populares. La muestra fue compuesta por 15 pacientes de una entidad de apoyo a las mujeres mastectomizadas. Datos obtenidos con una entrevista semi-estructurada se apreciaron de acuerdo con un sistema de clasificación que postula la existencia de cuatro categorías que se excluyen mutuamente: rechazo, estoicismo, aflicción y confrontación. Los resultados indican que el estoicismo fue la reacción emocional más frecuente en el grupo evaluado. La literatura científica muestra que el estoicismo puede contribuir a la reducción temporal del stress, pero que lleva gradualmente a un sentimiento de inutilidad qué tiende a crear dificultades para el ajustamiento psico-social a la enfermedad y el tratamiento.*

*DESCRIPTORES: neoplasias de la mama; pobreza; salud mental; adaptación psicológica*

## CÂNCER DE MAMA, POBREZA E SAÚDE MENTAL: RESPOSTA EMOCIONAL À DOENÇA EM MULHERES DE CAMADAS POPULARES

*O objetivo do estudo foi analisar as reações emocionais ao câncer de mama em um grupo de mulheres de camadas populares. A amostra foi composta por 15 pacientes vinculadas a uma entidade assistencial de apoio a mastectomizadas. Os dados foram coletados mediante o emprego de roteiro semi-estruturado de entrevista individual e apreciados em conformidade com um sistema de classificação que postula a existência de quatro categorias mutuamente excludentes: negação, estoicismo, aflição e enfrentamento. Os resultados obtidos indicam que o estoicismo foi a resposta emocional mais freqüente entre as pacientes analisadas. A literatura mostra que tal reação pode contribuir para a redução temporária do estresse, porém, conduz gradativamente ao invalidismo que tende a dificultar o ajustamento psicossocial à doença e ao tratamento.*

*DESCRITORES: neoplasias mamárias; pobreza; saúde mental; adaptação psicológica*

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## INTRODUCTION

**B**reast cancer is basically characterized by the occurrence of malignant tumors in one of the structures composing the organ, formed due to the uncontrollable reproduction of cells that went through a complex process of disordered transformations and may evolve by direct extension or metastatic dissemination. The main local symptoms are palpable nodes and deformations - especially cambers or retractions - in the breast. However, bloody nipple secretion and nodes in the armpits may be occasionally seen. Constitutional symptoms - such as asthenia, fever and weight loss - also compose the clinical condition[1].

Nowadays, this disease is the most common type of malignant neoplasm in the female population in many countries. Additionally, the incidence rates increase each year as a reflex of the global trend towards the predominance of lifestyles that promote exposure to risk factors. The most recent projections of the Ministry of Health appoint that, only in Brazil, approximately 50,000 new diagnoses would be confirmed in 2006 and that the risk ranges from 38 cases in the Central-West to 71 cases in the Southeast for every 100,000 women. For this reason, breast cancer control stands out as an increasing concern for national public health services[2].

In recent years, a decrease has been witnessed of the mean size of breast tumors and, consequently, a decrease of mortality rates caused by the disease, in a group of developed countries. After all, early diagnosis increases the potential treatment resolubility. Nevertheless, breast cancer still represents one of the major causes of death in the female population, especially in less privileged economical classes. This is because - due to the convergence of a number of factors such as low educational background, lack of information and restricted access to new therapies - in this population segment, secondary prevention is infrequent, even in the richest nations[3]. Moreover, among people in the same country, sharing the same culture, important regional differences are seen, due to social class, age, gender and attitudes, beliefs and values associated to health and disease.

In recent scientific literature, it is seen that studies are every time more oriented to psychosocial factors that would be associated to the difficulty of establishing an early diagnosis in breast cancer. Most of these studies show that, individually, behavioral beliefs associated to the lack of information and a distorted perception of the disease lead, in a higher or lower degree, to the avoidance of the breast self-exam, and restrict the request for mammograms and clinical breast examination among women living in poverty[4-5]. Such fact may be understood considering that, in spite of current scientific advances in oncology, the word *cancer* is still commonly viewed, in this population, as a synonym of pain, suffering, humiliation, mutilation and death[6].

The behavioral beliefs that make the adherence to the methods used in early breast cancer diagnosis difficult among women of lower purchasing power may also influence the emotional reaction to the disease and, thus, markedly compromise the effectiveness of strategies patients adopt in the fight to maintain their own lives[7]. Therefore, getting to know such beliefs is indispensable for healthcare professionals to avoid the disqualification of the popular experience of getting sick and, thus, to find means to maximize the reach of their interventions. Based on this principle, this study was conducted to analyzing the emotional reactions to breast cancer in a low-income group of women. Such purpose is warranted due to the lack of research of this nature, specifically developed with this population.

## METHOD

### Type of study

This study followed a descriptive, cross-sectional and qualitative design.

### Theoretical-methodological framework

In a classic study, a useful methodology was defined to evaluate the psychological impact of breast cancer. The emotional reactions moved by the disease in a sample of sixty-nine patients were evaluated three months after surgical therapy had been performed. Five years later, these responses were related to the treatment course. The results obtained show that there was a larger number of women free of the disease among those reacting to breast cancer with denial or showing a fighting spirit, than among those responding with stoic acceptance or feelings of destitution. Moreover, the results also suggest that affective

mobilization emerges from the contact with the diagnosis reality if based on a series of behavioral beliefs that support certain behaviors of health search[8].

This methodology consists in a classification system that presumes the existence of four mutually exclusive categories of emotional reactions to breast cancer, namely: *denial, stoicism, affliction and fighting*. The category *denial* refers to responses showing dissociation in the psychological experiences emerging from the diagnosis, frequently followed by evasive or indifferent attitudes. The category *stoicism* comprehends emotional reactions based on the belief that they must stand the suffering heroically. In this case, the disease may be seen as a trial that must be passively accepted or as a test to human limits, with nothing left to do, except conformation.

In the category *affliction*, the responses indicate that the emotional suffering the women experience due to the disease is very intense and surpasses the adaptive resources, so that she is unable to move to stop it. Finally, the category *fighting* classifies those behaviors, feelings and thoughts showing an attitude of fighting the situation directly. It is noteworthy that fighting the problem is supposed to be a positive adaptive resource, contrarily to the fighting centered on the emotion, which characterizes the three first categories of the system discussed.

## Causal relation

The study population consisted of 42 patients who, in the period comprehended by the research (March to December 2006), were enrolled in a care entity for social support to mastectomized women. The sample was composed of 15 patients screened for meeting the inclusion criteria, i.e., who: a) were 30 to 80 years old; b) were diagnosed for breast cancer at least three months earlier; c) did not show psychiatric precedents or suspected intellectual deficit; d) did not show evidence of recurrence or metastasis, and e) had a family income of up to two minimum wages.

The mean age of these study subjects was 57.5 years old, ranging from 49 to 72 years old. Table 1 systematizes a social-demographic characterization of the subjects and shows, regarding current occupation, marital status and educational background, respectively, that eight of them were housewives, nine were married and seven did not finish elementary school. Additionally, among the seven women with some remunerated occupation, occupations of low social prestige were predominant, requiring low or no educational background and professional qualification.

Table 1 - Social-demographic characterization of women with breast cancer. São Carlos - SP, 2006

| Subjects | Age | Educational Background | Current Occupation | Marital Status |
|---|---|---|---|---|
| 1 | 49 y-o | Incomplete elementary school | Housekeeper | Married |
| 2 | 58 y-o | Incomplete secondary school | Housewife | Married |
| 3 | 66 y-o | Incomplete elementary school | Housewife | Married |
| 4 | 62 y-o | Incomplete elementary school | Housewife | Widow |
| 5 | 52 y-o | Incomplete elementary school | Artisan | Cohabiting |
| 6 | 53 y-o | Incomplete secondary school | Cook | Single |
| 7 | 60 y-o | Incomplete elementary school | Housewife | Cohabiting |
| 8 | 55 y-o | Incomplete elementary school | Housewife | Married |
| 9 | 49 y-o | Incomplete elementary school | Ironing woman | Married |
| 10 | 57 y-o | Incomplete elementary school | Housewife | Single |
| 11 | 64 y-o | Incomplete secondary school | Dressmaker | Married |
| 12 | 69 y-o | Incomplete elementary school | Housewife | Widow |
| 13 | 72 y-o | Complete secondary school | Nursing aid | Married |
| 14 | 51 y-o | Complete secondary school | Sales promoter | Single |
| 15 | 46 y-o | Incomplete elementary school | Housewife | Widow |

## Instrument and Materials

For the data collection, a semi-structured interview script, a recorder and cassette tapes were used. The script emphasized the subjective aspects related to how the patients evaluate their health status and the emotional reactions unchained by the disease. The option for this kind of instrument was based on the principle that a semi-structured script would be able to make the examination of the emotional reactions caused by breast cancer viable, orienting the research according to certain aspects the researchers considered more relevant and, at the same time, offering the subjects the opportunity to configure the interview field according to their individual characteristics, thus helping them to show, in response to the questions they were asked, responses representing their conceptions, values and beliefs[9].

## Data collection procedure

The interviews were performed individually, face-to-face and audio-recorded with the subjects' agreement. The ethical conducts for research involving human beings were fully respected. This study is part of a broader project, approved by the Ethics Committee of FFCLRP-USP. All subjects gave

their formal agreement by signing an informed consent form, which explained their rights and emphasized the voluntary nature of their participation. It is also important to highlight that the investigators paid for the transportation expenses of the women to the care entity office, where the data collection was performed.

Data analysis procedure

The audio records were transcribed fully and literally. Subsequently, the emotional reactions to breast cancer mentioned by the patients were classified into four mutually exclusive categories - denial, stoicism, affliction and fighting - using the system already mentioned[8]. To avoid any eventual contamination of the results, the application of the interview analysis procedure was performed independently by two experienced judges (post-graduated psychologists). Consensually classified reactions were automatically accepted. The researchers discussed discrepancies case-by-case with the judges until a consensual agreement was reached.

## RESULTS AND DISCUSSION

The results obtained show that eight of the fifteen subjects (Subjects 1, 2, 3, 4, 6, 11, 12, and 15) faced breast cancer as a fatality, in view of which the only attitude possible would be passive acceptance. In these cases, even the anatomical losses incurred through surgical therapy caused conformism. This kind of emotional reaction, supported by a specific behavioral belief adopted as a resignation attitude, many times appeared as a way to suffocate potentially disrupting emotions, including indignation, rebellion and anger about the threat of a disease that could take her life. Therefore, it is seen that *stoicism* was the most frequent emotional reaction in the study sample.

The need to suffocate the emotions caused by the disease becomes understandable as the confirmation of a breast cancer diagnosis represents an important psychological trauma in most cases because, as supported by specialized scientific literature, the disease involves the main body symbolic support of woman's sensuality and sexuality[10]. Additionally, the physical consequences and emotional repercussions of the treatment usually affect the body image, not rarely leading to ruptures in the female identity. Without the breast, many patients feel restrained from what defines their nature. Therefore, according to a number of studies, breast cancer may be considered as one of the most feared diseases by women, independently of the social level[6].

The statement shown below exemplifies how stoicism could be identified, in the discourse of one of the subjects.

*At the time I was very scared. But then it was gone [...] Because our life is already written, right? I believe that everything is fate. So, what can we do? Nothing, right? (Subject 6).*

The notion of "fate" - which also appeared in the interviews as the expression "divine will" - was invoked in these cases to justify that, in view of what was supposedly designed for them ("written" in their *karma*), nothing could be done except accepting it passively. Some patients expressed this conformism by saying that they put themselves in the hands of a superior being or physicians, who could supposedly work according to the "divine will".

Emotional reactions of this nature tend to lead to a hesitating adherence to the treatment indicated because, even if the woman consents to follow recommended conducts, in her intimacy, there will always be room for doubt and disbelief. Is it worth to go through all these trials? Is this treatment really the best solution? Will everything be alright in the end? Questionings similar to these may arise. As everything is pre-defined by the destiny traced for each, the existence of efficient means to influence the apparently irremediable course of facts would be unlikely.

This incredulity also manifests itself in other ways. Three subjects (Subjects 5, 9 and 13) showed that, when the diagnosis was confirmed, they ignored the severity of the disease and, therefore, they delayed the start of treatment.. That is, in these cases, the disease led to *denial*. It is noteworthy to include that, as the statement below illustrates, one of the subjects examined mentioned that, even after completing the treatment, she questions the malignancy of her tumor.

*I did the chemo and the lump disappeared. Then, I thought it was not cancer. So, I didn't return to the doctor when the surgery was scheduled. I just went through the surgery later because I noticed that the lump had returned. But, to be honest, until now I have my doubts (Subject 5).*

The discredit of scientific knowledge and medical authority is, thus, noted.

The occurrence of this phenomenon is probably associated to the condition of poverty the study subjects live in as, for low-income people, to be sick means to lose the only resource they have to live: the ability to work[11]. This way, to deny the disease may be a way to keep the routine of housekeeping or professional activities and to favor the provision of basic needs, such as food and housing. Moreover, it is frequently believed, in the popular context, that a "woman cannot give herself the luxury of being sick", as the essential role to keep the family's well-being belongs to women, who often leave their own well-being aside.

Only two patients (Subjects 8 and 10) reacted to breast cancer by *fighting*, as they actively sought information about their own prognosis, did not surrender before the difficulties inherent to the treatment, did not feel stigmatized by the disease and did not feel resentment by the mutilation or oppression by feelings of shame. The report below shows how this reaction could be identified in the discourse of one of the women.

*I asked the doctor what it would be like. It was the first thing I did. He explained everything. Then I did everything I had to do. […] Did you know that I knew a woman at the hospital who did not accept the treatment? And she really didn't do it! So she died. Wow, this never crossed my mind! (Subject 8).*

The active search for information from healthcare professionals frequently translates the will to feel again in the control of the facts of their lives. This basic feeling is partially taken away by the appearance of a severe disease like breast cancer. Therefore, to adopt a combative and realistic attitude before the disease may have a reparatory character, i.e., it represents an attempt to regain self-dominion upon what happens to you. To have this kind of posture towards her own disease can make the difference, probably distinguishing survivors from patients who die because they ignored the danger, as mentioned before in the evaluation of the emotional reaction shown by Subject 8.

However, it is emphasized that, to fight the disease, a subjective involvement with one's own body is required. The scientific literature shows that, generally, in popular levels, the personal physical resources are too used at work[11]. On the other hand, little attention is given to body experiences outside this context. That is: a reflexive relation to the body seems to be incompatible with its exploration in the performance of productive activities. This reasoning would explain, at least partially, the fact that the *fighting* highlighted as an emotional reaction to the disease is uncommon among these study subjects.

In two cases (Subjects 7 and 14), a marked emotional mobilization was seen during the interview, justifying the classification of *affliction* as a predominant emotional reaction. This possibly occurred because the perspective of recurrence was lived as an imminent threat, from the metaphorical point of view, analogue to that represented in mythology by Damocles' sword. Anguish and pursuit remain in these subjects' discourse, monopolizing their concerns with a possible reoccurrence of breast cancer, as may be seen in the report below.

*Look, nobody knows what I've been going through. I'm scared, desperate! The doctor said that the surgery is not a certainty. I thought that it was just to take out the tumor and it was done. But he said it may appear somewhere else. There is a large risk (Subject 14).*

Some of the reasons associated to the prevalence of stoicism in this study are easily assumed, considering that many studies show how disturbing breast cancer may be. In one of them, it was found that one-fourth of the women diagnosed for one year met the criteria for some psychiatric disorder - especially anxiety, depression and sexual dysfunction - even if mild[12]. Another research showed that four in five patients experience reactions of psychological suffering in the face of the diagnosis and half of them intensely enough to be considered as a psychiatric disorder[13].

However, the results of this study suggest that, in low-income patients the elaboration of the popular experience of getting sick is specifically influenced by an automatic association between breast cancer and a painful physical deterioration process with no parallel in human existence. Such association seems to be especially marked in this population and, as already mentioned, in general, it is essentially due to the lack of information and emotional approximation with cancer. Additionally, it usually feeds behavioral beliefs that make adherence to secondary prevention difficult and, consequently, make early diagnosis impossible[4]. It is exactly for this reason that the patient's social level is considered an important prognosis factor in breast cancer[14].

Research also shows that the most frequent emotional reaction to breast cancer in this study sample tends to promote, in patients with tumors in different locations, the restraint of efforts whose use in the

transactions between the subject and the context would be potentially opportune for physical and mental health promotion. Although it contributes to a temporary decrease in stress, this process gradually leads to invalidism, extending beyond the objective limitations imposed by the disease and, thus, it may compromise the dynamic adjustment to the inherent demands of each of the steps to come, from diagnosis to treatment[15-16].

The actual implications of this *invalidism* for the mental health of patients from popular levels are still unknown, as the studies supporting their associations to stoicism were not specifically developed for this population. However, it seems reasonable to think that the phenomenon mentioned, promoting a deficit in the performance of productive ability and intensifying material privation, would dramatically affect the sense of self-efficacy - i.e. the perception of being competent to perform different daily activities - in women living in poverty. After all, this would cause a continuous and progressive process of *disaffiliation* regarding the capitalist mode of production current in the globalized world.

## FINAL CONSIDERATIONS

In spite of the perspective obtained by hearing a relatively small number of patients, this study shows that the emotional reaction of women from popular economic levels to breast cancer may be related to the unfolding of poverty conditions, which frequently include limited access to information and treatment resources. Moreover, it suggests that, in this population, poor adaptive strategies tend to be adopted in the management of the emotional repercussions of the disease and treatment. The findings also corroborate evidence that, in patients with breast cancer, certain traces of personality are frequent, such as the tendency to suppress emotions, especially anger, and to respond to stress by using a repressive fighting style[12]. New research is definitely required, but the results reinforce the notorious need for multidisciplinary healthcare educational programs, compatible with the cognitive and affective universe of low income women, with a view to the popularization of secondary breast cancer prevention.

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