Journal of Medicine, Physiology and Biophysics
ISSN 2422-8427 An International Peer-reviewed Journal
Vol.29, 2017


# The Influence of the Psychological Care on the Psychological Recovery of Mastectomy Patients Case Study of Al-Amal Cancer Center

Dr.Marwan Khalaf Zureikat
Ministry of Health, Amman - Jordan

**Abstract**
The current paper is a try to examine the influence of the psychological care on the recovery of the Modified Radical Mastectomy patients. Mainly, the paper aims at understanding the role of having a well-built psychological program to fasten the recovery of modified radical mastectomy patients on more than one level. The sample of the study consisted of nurses of different levels who have a direct access to the patients within Al-Amal cancer center in Jordan. The study took into perspective four levels of psychological fields including (body image, family, support group and surgery). According to the results of the study, as 144 participants answered the questionnaire properly it appeared that the most influential part which should be taken into consideration through the recovery process is the body image, it appeared that the body image is one of the most important aspects that supports the recovery of a woman after the surgery of mastectomy and helps deeply in giving a healthy approach to deal with the patients after the change that took place on their bodies. In addition to that, it appeared that self-perception (body image), unsettling influence, and lower self-empathy were connected with expanded mental trouble among breast cancer survivors.
**Keywords:** Breast Cancer - Breast Mastectomy – post-surgery recovery

## Introduction

Breast Cancer is the second most common risk in ladies and second driving reason for malignancy passing in females. Like every long term sickness breast growth additionally includes a progression of dangers and troubles, which additionally prompt to the improvement of mental issues in the patients. The term malignancy alludes to a heterogeneous gathering of more than 100 particular sorts of tumor that are described by deregulated and quick cell development and the potential for intrusive or metastatic development (American Medical Association-AMA, 1989; Delhanty and Baum, 2001). Tumor harms the DNA inside cells. Disease preys on the host and keeps on becoming uncertainly contending with typical tissues for nourishment. Sorts of malignancy fluctuate significantly concerning hazard components, etiology, sickness course, and treatment. Contingent upon the site of the first tumor, its size, or whether it has metastasized, distinctive diseases take after various courses. A few growths are to a great degree forceful, take after an extremely unsurprising malady course, and seem to advance unyieldingly as a component of organic variables (Levy and Wise, 1987). Others, including breasts malignancy, take after more factor ailment courses, have all the earmarks of being less solely influenced by cancer science, and appear to be influenced by different components i.e. stretch and psychosocial variables.

## The Reality of Breast Cancer

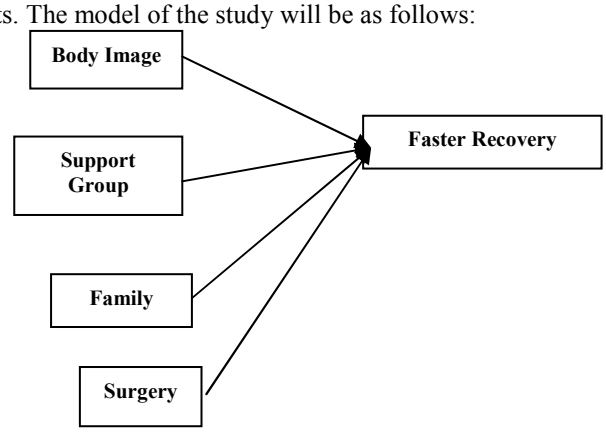
Breast cancer is the second most basic danger in ladies and the second driving reason for death. Breast cancer is three circumstances more normal than all gynecological malignancies set up together. The frequency of breast cancer has been expanding relentlessly from a rate of 1:20 in 1960 to 1:8 ladies today. Breast cancer is not solely an ailment of ladies. For each 100 ladies with breast cancer, one male will likewise build up the malady. Breast cancer is analyzed regarding different stages, which likewise help in the forecast and in choice for treatment required. Stages are resolved regarding different organizing frameworks; most relevant are Duke's and Astler's Collar Staging System, Clark's level staging system, and TNM classification system. The most mainstream arranging system is "TNM" grouping which portrays measure/number of the essential tumor symbolized by the letter 'T', though letter "N" is signified for lymph hubs, and the status of metastasis is meant by letter 'M'. Arrange 0 in the breast cancer is utilized to portray noninvasive breast cancer without confirmation of tumor cells attacking typical tissues. Stage I delineates intrusive breast malignancy comprising of tumor measured up to 2 centimeters, and no lymph hubs are included. Stage II portrays obtrusive breast malignancy in which tumor measures somewhere around 2 and 5 centimeters, or the disease has spread to the lymph hubs under the arm on an indistinguishable side from the breast cancer influenced lymph hubs have not yet struck to each other. Stage III is separated into subcategories known as 3A and 3B. Stage IIIA depicts obtrusive breast growth in which the tumor measures more than 5cms or the tumor has spread to lymph hubs and hubs are adhering to each other or encompassing tissue. Stage IIIB delineates breast malignancy in which tumor of any size has spread to the breast skin, mid-section divider, or inner mamalary lymph hubs and incorporates fiery breast growth. Stage IV is referred to as propel stage as it incorporates intrusive breast malignancy in which the tumor has spread past the

breast and interior mamalary lymph hubs. Determination of breast cancer includes the utilization of general medicinal examination and some particular research center procedures, for example, palpation, mammography, ultra-sonography, needle biopsy, and surgical biopsy.

**Problem Statement**

There is no suspension that the psychological care plays a huge role in fastening the recovery of patients specially those whose illness has put on them a need for a change in their bodies. Modified Radical Mastectomy patients are among the type of patients whose psychology has a deep influence on their response to medication. The current research tries to understand the influence of the psychological care on the recovery of Modified Radical Mastectomy patients. The model of the study will be as follows:




**Hypotheses of the Study**

Based on the model above, the main hypotheses of the study will be

**Main Hypothesis**: Psychological care has a profound impact on a fastening the recovery of Modified Radical Mastectomy patients.

Sub-Hypotheses will be:

**H1**: Body image psychological framework fastens the recovery of Modified Radical Mastectomy patients.

**H2**: Support group fastens the recovery of Modified Radical Mastectomy patients.

**H3**: Family awareness fastens the recovery of Modified Radical Mastectomy patients.

**H4**: Pre-surgery knowledge fastens the recovery of Modified Radical Mastectomy patients.

**Literature Review**

**What is Cancer**

Cancer is a broad term that is used to describe heterogeneous group of over 100 specific forms of cancers (Friedman, Kalidas, & Elledge, 2006). These cancers are characterized by the potential for metastatic or invasive growth, rapid cell growth, and deregulated cell growth. Cancer may damage the cells' DNA by preying on the host and continuing to grow indefinitely as it competes for nutrition with normal tissues. Different types of cancer have unique etiology, treatment, and risk factors. Different cancer may follow difference courses depending on the size of the tumor, and site (Vahdaninia, Omidvari, & Montazeri, 2010).

**Breast Cancer**

Breast cancer like other types of cancer affects human tissues. It affects the human breasts. It targets the milk ducts. A malignant tumor develops at the inner lining of the milk ducts. Some of the cells of the malignant tumor then start spreading to other sections of the body (Hack, & Designer, 2004). The two common types of breast cancer are the ductal and lobular carcinoma. Lobular carcinoma originated from the inside section of the lobules, whereas ductal carcinoma starts from the breast ducts (Friedman, Kalidas, Elledge, 2006).

According to Friedman, Kalidas, and Elledge (2006) a large percent of women are affected by breast cancer than the males. Of all the cancers that affect the females, breast cancer takes 16% prevalence in females. It is given a percentage of 22.9% of invasive cancer types in females. The disease accounts for over 18.2% of deaths across the globe. A study conducted by the NCI (National Cancer Institute) reported that in every year, over 232,000 females and 2,000 males are affected by breast cancer in the United States. Further, over 39,000 deaths in USA each year result from breast cancer (Friedman, Kalidas, & Elledge, 2006).

In developed nations, the number of people struggling with breast cancer is higher than that of persons in developing nations. Some of the factors that make the rates of breast cancer to be high in developing nations is life expectancy. A bigger percentage of patients with breast cancer are elderly women (Vahdaninia, Omidvari, & Montazeri, 2010). As people live longer in developed nations, they increase the likelihood of developing breast

cancer. Additionally, lifestyles that promote limited exercise increase the risk for one to have a breast cancer. Consumption of unhealthy fast food has also been associated with cancer prevalence (Hack, & Designer, 2004).

**Empirical Data on Breast cancer in the world**

Studies have consistently identified breast Cancer as the most prevalent type of non-skin cancer in female population in both developing and developed countries. In 2004, there were 1.15 million new cases of breast cancer and about 500,000 breast cancer related deaths globally (Parkin and Fernandez, 2006). According to Parkin and Fernandez (2006) more than 50 percent of these breast cancer cases occurred in developed countries. Similarly, Parkin et al. (2005) confirmed that breast cancer was responsible for the high cancer-related mortality rates among women globally. According to Parkin et al. (2005) breast cancer was the key cause of cancer-related deaths in women globally in 2005. Other updated studies (e.g., Ferlay et al., 2010; Kolahdoozan et al., 2010; Jacques et al., 2010; Ferlay et al., 2010; Ferlay et al., 2013; Wilson, Miller & Edge, 2012), found a similar trend. For instance, Ferlay et al. (2010) indicated that in 2008, breast cancer accounted for 458,400 (14 percent) of all cancer-related deaths and was considered the second most common form of cancer that accounted for 10.9 percent of all cancers and as the fifth cause of cancer-related deaths. It was indicted that the incidence rate of Breast Cancer in women varies across regions: 89.9 women per every 100,000 women within Western Europe; 19.3 women per every 100,000 women within Eastern Africa. It is also indicated that 80 women per 100,000 women within the developed countries (except Japan), and 40 or less women per 100,000 women in developing countries. It was also revealed that the indicated that incident rates of breast cancer are projected to increase in future in transition regions such as Latin America and Asia. According to Curado (2011) incident rates of breast cancer vary worldwide: it is highest in countries within Europe and that it is on an increasing trend in both Latin America and Asia. This increase in the rates of Breast Cancer in these countries is attributed to poor screening practices and the aging population. Incident rates of cancer are often produced by PBCRs (Population-Based Cancer Registries) globally: however, only few regions ranging 1 percent to 5 percent of Africa, South America and Asia. Ferlay et al. (2010) further suggested that breast cancer associated mortality rate is high in low-income and middle-income countries than in high-income countries (Ferlay et al., 2010). Similarly, Kolahdoozan et al. (2010) identified breast cancer as the most common type of cancers in women in both developed and developing countries accounting for about 10 percent of all forms of cancers in women worldwide (Jacques et al., 2010). It also the leading cause of cancer-related deaths in women in both developed and developing countries (Jacques et al., 2010).

In a more recent study, Ferlay et al. (2012) identified breast cancer as the most common form of cancer affecting women worldwide. According to Ferlay et al. (2012) about 1.7 million new cases of breast cancer were diagnosed in 2012. According to Ferlay et al. (2012) this represented 25 percent of all types of cancers in women and 12 percent of the total new cases of cancer. Ferlay et al. (2012) identified countries with highest incidents of this form of cancer: Belgium, Denmark, France, The Netherlands, Bahamas, Iceland, United Kingdom, Barbados, United States, Ireland and others. Elsewhere, Wilson, Miller and Edge (2012) indicated that 1 in every 8 women has Breast Cancer in America. Consistent with previous study findings, it was revealed that over fifty percent (52.9 percent) of 1.67 million newly diagnosed breast cancer cases occurred in developing countries (Ferlay et al., 2013). According to Ferlay et al. (2013) 62 percent of deaths that occurred in developing countries in 2012 were caused by breast cancer. Ferlay et al. (2013) emphasized that the etiology of breast cancer involves a multitude of hormonal, reproductive, exogenous and genetic factors that modify and increase the risk of breast cancer.

**Pre-diagnosis**

Most people undoubtedly fear the diagnosis of breast cancer and it requires psychological adjustment for individuals who are subjected to diagnosis. According to Rabin and Pinto (2006) pre-diagnosis stage is often characterized by fear and uncertainty for the concerned individuals or family. The challenge experienced by most breast cancer patients is that they often tend not to recognize or ignore the presenting signs and symptoms. Signs and symptoms of breast cancer are insidious with pain being experienced at the very advanced stage of the disease. This is also a contributing factor to late diagnosis of breast cancer cases. During diagnosis, the physicians often conduct a full clinical examination. The most accurate and commonest diagnosis involves the breast biopsy. (Brothers & Anderson, 2008).

**Post-diagnosis**

Studies suggest that most breast-cancer patients tend to experience psychiatric problems post-diagnosis (Tomich & Helgeson, 2006). The widely reported psychiatric problems include anxiety, adjustment problems, depression, sexual dysfunctions, disability, and disfigurement. Elsewhere, Ganz (2008) indicated that individuals diagnosed with breast cancer tend to experience changes in almost every aspect of their lives including interpersonal, physical, spiritual, vocational, and psychological domains. According to Brothers and Anderson (2008) breast

cancer survivors are more likely than those without it to experience psychological problems, functional limitations, and poor health, such as the inability to work or drive. Individual diagnosed with breast cancer at a younger age have been reported to have the highest risk of psychological problems. Ando et al. (2009) classified breast cancer psychiatric morbidity into three: morbidity related to treatment modality; those related to diagnosis; and those related to terminal stages of the disease. Supporting the findings by Ando et al. (2009), Beatty et al. (2008) indicated that the commonly identified emotional reactions in individuals diagnosed with breast cancer include denial, anger, depression, shock, anxiety, disbelief, and guilt.

According to Sarenmalm et al. (2008) factors that sustain emotional distress in individuals diagnosed with cancer include pain, fear of pain, incurability, recurrence of the disease, disfigurement, and some sense of hopelessness and helplessness concerning its treatment. Psychiatric morbidity have also been observed in family members for breast cancer patients including depression and school phobia in siblings, enuresis, psychosomatic, psychosocial and psychosexual problems and conversion reactions among parents, and depression and anxiety in spouses (Schmid-Büchi et al., 2008; Stuartet al., 2006).

**Pre-surgery and Post-surgery**

Surgery gives hope to breast cancer patients. It improves their survivorship. According to Gospodarek (2009) the survivorship of cancer patient varies depending on various factors, including the stage, treatment utilized as well as the type of cancer. The stage of cancer also depends on the size of the tumor and whether it has multiplied and spread beyond the patient's lymph nodes (Allen, Savadatti, & Levy, 2009). Higher stage number indicates that the disease is extensive. Patients diagnosed with stages 1 and II (i.e., earlier stage cancers) have high rate of survival compared to those diagnosed with advanced stage breast cancers. The surgical treatment utilized can lead to a myriad of distressing, potentially-life threatening and painful side effect, including increased risk for secondary tumors. The documented increase in the number of breast cancer survivors has changed the perception about breast cancer resulting in people adopting to the new reality and finding it as normal after they have undergone surgery. This has largely been contributed by advances made in cancer screening technologies, cancer detection supportive care, maintenance therapies following surgery. However, as observed by Gospodarek (2009), the threat of the disease recurring may loom in cancer patients who have undergone surgery and may demonstrate high adaptability causing them to go into remission with some patients become psychologically paralyzed. Gospodarek (2009) indicates that how well a cancer patient adapts following a cancer diagnosis and surgery can have an impact on the disease progression and medical consequences. Cancer patients found to have high levels of depression and hopelessness do not adapt or survive as those with low levels of depression and hopelessness. Cancer patients with high stress levels have poor coping mechanism when it comes to immune system activity. Evidence suggests that an impaired immune system tend to increase the progression of cancer into other stages. Psychological factors have also been shown to affect a cancer patient to carcinogens (i.e., smoking and alcohol abuse) through psycho-maintenance (sustaining behavior pattern), patient survival and compliance to the treatment (Allen, Savadatti, & Levy, 2009).

**Breast Mastectomy**

There are two surgical options when it comes to breast cancer: mastectomy (MT) or breast conservative therapy (BCT) (Giannopoulos, & Vella-Brodrick, 2011). The modified radical mastectomy is often used to treat cancers that are confined to the regional lymph nodes or breast. It involves removing the some fat o and the axillary lymph nodes and the breast. However, the pectoralis remains intact to help reduce the possibility of chest deformity. It risk of lymphoedema is law. This allows the patient to regain her shoulder movement. Another type of surgery for patients diagnosed with breast cancer is called Halstcd mastectomy (McGaughey, 2006). This type of surgery involves the removal of the whole breast along with the underlying lymph nodes, fat and pectoral muscles. This surgery operation tends to leave the patient with swelling, limited shoulder movement, and lost strength in the affected arm. It also causes a sunken or flattened chest wall and disfigured scars. In cases where breast cancer s found to have extended beyond the patient's breast area, it may be necessary to use other treatment involving the use of radiotherapy or chemotherapy. These surgical procedures leave the patient mutilated and disfigured. As such, they are a threat to the femininity of a woman. Families and the affected patient may experience considerable strain due to the increased fear of the disease recurring and the threat to their body shape and femininity.

Researchers have found high incidences of morbidity among patients who have undergone mastectomy. It is suggested that 20-40 percent of mastectomy patients develop severe depression requiring psychiatric help (McGaughey, 2006).

McGaughey (2006) also revealed that BPM (Bilateral Prophylactic Mastectomy) can reduce the risk of a woman developing breast cancer by 70-80 percent. According to McGaughey (2006) women thought to be at a high risk of developing familial breast cancer are considering BPM for prevention. According to McGaughey (2006) BPM is believed to be effective in reducing anxiety of developing breast cancer. Psychological Support

of Modified Radical Mastectomy patients

**Group Support**

Breast cancer patients can benefit from psychosocial support groups like online support groups, and group canceling. There is evidence that social support may lead to positive impacts on the outcome (Han et al., 2008). In this case, a breast cancer patient is given an opportunity to talk his or her illness, and allowed to talk about her feelings. The peers listen to the patient talking. Such an intervention helps reduce the level of stimulation is the patient hence reducing the likelihood of such a patient to have a depression or PTSD (Kim et al., 2010).

The group psychological intervention has been reported to bring positive outcomes in managing psychological challenges that come from breast cancer. Group intervention helps minimize distress level while enhance the coping skills. Han et al. (2008) asserted that group interventions may result into a better quality of life for the survivors of breast cancers. It does reduce the emotional distress, and improve the adjustment to the new life. A patient is also able to come up with coping skills that facilitate better psychological, physical, and social health in the medium and short term.

**Family support**

When one member of a family is diagnosed with breast cancer, the whole family will be affected in different ways. The adults and the young children in the family will all be affected by the disease (Giannopoulos, & Vella-Brodrick, 2011). As the patient struggles accepting her illness, her family will equally struggle to accept the fact that one of them will be leaving them soon. If the patient has children, these children will suffer due to the emotional distress of their parent.

The psychosocial support for the family of the patient with breast cancer could include accessing a mental health counseling, group support, psycho-education, among other services (Garlick et al., 2011). The entire family can be invited for counseling therapy with the patient, and a counseling sessions is conducted to all members of the family (Giannopoulos, & Vella-Brodrick, 2011).

The members of the family will then be advised to provide the patient will all the support and love they needs to go through the treatment. For example, the family is expected to spare a large sum of money towards the treatment of their loved one. If she has children, the family members can help her to take care of her kids when she is going through the chemo. If all the support is given to the patient, then she is likely to improve her psychological wellbeing (Horgan, Holcombe, & Salmon, 2011).

**Surgery**

Surgery is so far the most common and preferred treatment for breast cancer. The two most common surgeries for women diagnosed with breast cancer are Lumpectomy or Tylectomy and modified radical mastectomy (Wolff, 2007). The former is suited for women patient with breast cancer that is still in its early stages. This surgery involves the removal of tumors and the tissue surrounding it. This is often accompanied with radiotherapy. This technique is less mutilating when compared to other surgeries, and it does also take into account the issue of cancer being multicentric. Radiotherapy can cause fibrosis and depression. Total or simple mastectomy involves the removal of the entire breast, leaving only the axillary nodes and pectoral muscles intact. This helps help reduce the likelihood of lympoedema and avoid minimize the possibility of sunken chest often left by mastectomy (Giannopoulos, & Vella-Brodrick, 2011).

The modified radical mastectomy is often used to treat cancers that are confined to the regional lymph nodes or breast. It involves removing the some fat o and the axillary lymph nodes and the breast. However, the pectoralis remains intact to help reduce the possibility of chest deformity. There is also low risk of lymphoedema. This allows the patient to regain her shoulder movement (Giannopoulos, & Vella-Brodrick, 2011). Another type of surgery for patients diagnosed with breast cancer is called Halstcd mastectomy. This type of surgery involves the removal of the whole breast along with the underlying lymph nodes, fat and pectoral muscles (Stanton et al., 2000). This surgery operation tends to leave the patient with swelling, limited shoulder movement, and lost strength in the affected arm. It also causes a sunken or flattened chest wall and disfigured scars. In cases where breast cancer s found to have extended beyond the patient's breast area, it may be necessary to use other treatment involving the use of radiotherapy or chemotherapy (Zabora et al., 2001). These surgical procedures leave the patient mutilated and disfigured. As such, they are a threat to the femininity of a woman. Families and the affected patient may experience considerable strain due to the increased fear of the disease recurring and the threat to their body shape and femininity (Wolff, 2007).

**Body Image**

According to Przezdziecki et al., 2012 the individual's body image is the perception about herself. It tends to be modified by life events. Various factors may modify or contribute towards body image including attitudes of peer groups, society and patents, as well as culture and environment (Zabora et al., 2001). Body image is

considered the root of self-esteem and identity and changes introduced by surgical operation may lead to the disruption of the patient's body image. To a woman, breasts are the most conspicuous and external self-related organs. The losing the breast results in disfigured scars and asymmetry, and alter the woman's body image. It may lower her self-esteem; pose a threat to the woman's sexual desirability; and attractiveness to other people. The body image has four interrelated aspects: evaluative, behavioral, affective and cognitive components (Wolff, 2007). The cognitive component refers to the accuracy with which an individual estimates his or her body size, particular body parts, or entire body. It involves interpreting external sensation including observing one's internal sensation and reflection (Stanton et al., 2000). Affective body image refers to one's emotional response that is caused by an individual being engendered by his or her thoughts about the part of the body or the entire body. On the other hand, the behavioral component refers to one's reflection towards or about the body (Stanton et al., 2000). The evaluative component refers to the way a person rates hers body image. For breast cancer patients, body image distress refers to the patient's subjective psychological stress accompanying the negative thoughts, feelings, emotions, and behaviors resulting from breast surgery and breast cancer (Zabora et al., 2001).

**Methodology**

There are many approaches to carry out a certain research and reach the needed set of answers for the dilemma of the research. In the medical/social research there can be carried researches in two main approaches which are the quantitative and the qualitative. The current research is following a quantitative approach in delivering the best answers to the questions of the study which are being carried out.

The quantitative approach in the social research is all around understanding a certain phenomenon in the society and examines its influence in driving the members of the society into a certain point of interest. Here, the quantitative approach is a approach to examine the influence of a well-built psychological program in fastening the recovery of Modified Radical Mastectomy patients.

**Tool of the Study**

The adopted tool in the current research study is the questionnaire which takes into perspective the variables of the study and tried to draw the connection between these variables and the recovery of the patients. The questionnaire was built by the research based on previous studies which took into its perspective one of more of the variables under examination. Questionnaires are considered to be one of the direct measurement approaches that can give knowledge about a certain phenomenon in the society through numerical data, these data can be translated into results in accordance with the frequencies and means of the sample results which gives a deep understanding of the notion under examination.

**Population and Sample of the Study**

In the current research, the population will be formed from all of the nurses, staff nurses, and heads of the nursing departments in Al-Amal Cancer Center. The sample will be convenience sample which is seen to be a non-probability sampling technique. The total number of participants which the author managed to reach is a total of 157 members who were from different positions in the center including nurses, staff nurses, and interns. The questionnaire was distributed on a total of 157 member who were willing to take part in the study, 144 questionnaire retrieved were filled properly and were able to be statistically processed

**Data Analysis**

The current section presents the statistical analysis of the questionnaire which was filled by the nurses who normally deal with the beast cancer patients and on regular bases.

**Demographic Variables**

The following section presents the demographic analysis of the description of the sample of the study. Frequency and percentages were computed for the sample's characteristics.

**Table (1): Frequency and percentages were computed for the sample's characteristics according to gender**

| gender | | | | |
|---|---|---|---|---|
| | Frequency | Percent | Valid Percent | Cumulative Percent |
| F | 105 | 72.9 | 72.9 | 72.9 |
| M | 39 | 27.1 | 27.1 | 100.0 |
| Total | 144 | 100.0 | 100.0 | |

As it can be seen from the above table (1), 72.9% of individuals who responded to the questionnaire were females nurses compared to 27.1% of male nurses which draws the attention that female nurses are more involved with breast cancer patients and more into their psychological status and aware of their recovery journey.

**Table (2): Frequency and percentages were computed for the sample's characteristics according to position**

| position | | | | |
|---|---|---|---|---|
| | Frequency | Percent | Valid Percent | Cumulative Percent |
| CNA | 9 | 6.3 | 6.3 | 6.3 |
| LPN | 10 | 6.9 | 6.9 | 13.2 |
| RN | 86 | 59.7 | 59.7 | 72.9 |
| APRN | 39 | 27.1 | 27.1 | 100.0 |
| Total | 144 | 100.0 | 100.0 | |

In the table (2) above, it can be seen that the highest percentage was for the registered nurses (RN) which scored 59.7% of the total sample. Basically, the reason behind the high percentage of RN responses to the questionnaire is attributed to the fact that RN usually helps doctors in giving treatment to patients experiencing different restorative conditions. They may direct solution, supervise the recovery of the patients, and teach patients and their families how to deal with their situation away from the hospital and with the comfort of their own homes. In another meaning, a registered nurse has a direct and continuous contact with the patient and their families which give them a direct access to the development of the patient all through the recovery process.

**Table (3): Frequency and percentages were computed for the sample's characteristics according to experience**

| experience | | | | |
|---|---|---|---|---|
| | Frequency | Percent | Valid Percent | Cumulative Percent |
| 4-9 | 25 | 17.4 | 17.4 | 17.4 |
| 10-15 | 48 | 33.3 | 33.3 | 50.7 |
| 16-20 | 71 | 49.3 | 49.3 | 100.0 |
| Total | 144 | 100.0 | 100.0 | |

The above table (3) shows the distribution of the sample according to the experience; the table shows that the highest percentage of the sample which participated in the study was individual who had experience more between 16-20 years with a percentage of 49.3% of the total participants; followed by individual who had an experience of 10-15 years with a percentage of 33.3% of the total participants.

**Analysis of the questionnaire paragraphs**

The following part showed that mean and standard deviation are used to describe attitudes toward following questions:

**Table (4): Mean and standard deviation of the questions**

| Descriptive Statistics | | | | | |
|---|---|---|---|---|---|
| | N | Minimum | Maximum | Mean | Std. Deviation |
| **Body Image** | | | | | |
| Women consider mastectomy as a stigma in their bodies | 144 | 1.0 | 5.0 | 3.431 | 1.2936 |
| Women who are satisfied with their body shape may still perceive deficiencies during to mastectomy | 144 | 1.0 | 5.0 | 3.819 | 1.3044 |
| Psychological refusal may increase the amount of recovery | 144 | 1.0 | 5.0 | 3.104 | 1.3675 |
| Cancer patients must be trained to express their feelings towards their bodies | 144 | 1.0 | 5.0 | 2.875 | 1.4859 |
| Consistent application of valid and reliable measures of body image specific to breast cancer women is needed. | 144 | 1.0 | 5.0 | 3.049 | 1.3707 |
| Offering the patients information about mastectomy helps them to accept their bodies and fasten the recovery process | 144 | 1.0 | 5.0 | 3.840 | 1.0882 |
| Body image problems can encompasses more than physical attributes and describes overall wholeness, functionality, and ability to relate to others | 144 | 1.0 | 5.0 | 3.389 | 1.3541 |
| **Family** | | | | | |
| The role of family is important in providing support to mastectomy patients | 144 | 1.0 | 5.0 | 3.451 | 1.1333 |
| various assistance provided by the family to help the recovery of the patient | 144 | 1.0 | 5.0 | 3.396 | 1.2015 |
| The husband is the most important member of the family to provide support to mastectomy patient | 144 | 1.0 | 5.0 | 3.583 | 1.4604 |
| The first response of the family can influence the nature of the coming stages | 144 | 1.0 | 5.0 | 3.528 | 1.4433 |
| The whole family should understand the nature of the disease to support their patient | 144 | 1.0 | 5.0 | 2.764 | 1.2626 |
| Being able to undertake various changes in the household is important to the recovery of the patient | 144 | 1.0 | 5.0 | 3.167 | 1.3009 |
| Family helps in providing social support to women post Radical Mastectomy | 144 | 1.0 | 5.0 | 2.785 | 1.2581 |
| Family increase knowledge in providing nursing care to patients Breast Cancer Post Radical | 144 | 1.0 | 5.0 | 2.951 | 1.3292 |
| **Support Group** | | | | | |
| Sharing experiences can help in increasing the psychological health of a mastectomy patient | 144 | 1.0 | 5.0 | 3.035 | 1.4113 |
| Support group of women with breast cancer could inhabit a space that provides moments of joy and pleasure | 144 | 1.0 | 5.0 | 3.431 | 1.2608 |
| Sharing a breast cancer experience with strangers is not favored by most patients | 144 | 1.0 | 5.0 | 3.292 | 1.2340 |
| Patients with breast cancer are usually eager to meet someone who has the same condition | 144 | 1.0 | 5.0 | 3.007 | 1.2874 |
| There are a lot of cases in which support groups proved its efficiency in increasing the speed of the recovery | 144 | 1.0 | 5.0 | 3.285 | 1.3098 |
| The hospital gives the patients the option to enroll in a support group | 144 | 1.0 | 5.0 | 3.493 | 1.3116 |
| **Surgery** | | | | | |
| Not all patients show interest in understanding the procedure of the surgery | 144 | 1.0 | 5.0 | 3.146 | 1.3739 |
| It is important that the patient is aware of what is going to happen inside the operation room | 144 | 1.0 | 5.0 | 2.958 | 1.4478 |
| Doctors makes sure to explain the surgery for the patient in simple words | 144 | 1.0 | 5.0 | 3.347 | 1.5067 |
| The awareness of the patient about the surgery can decrease the speed of the recovery process | 144 | 1.0 | 5.0 | 3.299 | 1.4680 |
| I see that explaining the procedure of the surgery is not that important | 144 | 1.0 | 5.0 | 3.076 | 1.3694 |
| Explaining the procedures of the surgery is bound to the age and condition of the patient | 144 | 1.0 | 5.0 | 3.500 | 1.2060 |

According to the table (4) above it can be seen that the paragraphs are split according to the variable that is take into perspective. As for the variable of body image, it can be read through the table that the most influential paragraph was the 4th paragraph articulated "Offering the patients information about mastectomy helps them to accept their bodies and fasten the recovery process" which gives an indication about the importance of the awareness among patients and its role in speeding the recovery process not to mention its role in helping patients accepting their body image after the mastectomy process and start learning how to deal with the new status that they find themselves in. This matches what Fallbjork and others (2013) noted that a greater number of ladies than beforehand survive breast cancer yet the treatment administrations are shockingly joined by a scope of physical, mental, existential, and social concerns. There is by all accounts an adjustment of self-perception, including sentiments of womanliness and appeal, between 10 months and around 3 years post-surgery. There is even a positive pattern towards change. This discovering stands out from the finding that sexual engaging quality and sentiments of solace amid sexual closeness appear to wind up distinctly more risky with time and are consequently of incredible sympathy toward ladies treated for breast growth. Sexuality is regularly a basic piece of life and the finding that this territory of life does not appear to be reestablished, and, indeed, even decreases, regardless of whether the breast is recreated or not, is an issue to consider. It has already been demonstrated that social insurance staff are not enthusiastic to start dialogs about sexuality with patients.

As for the second variable which is the family, it appeared through the analysis that the most answered

paragraph was the 3rd one articulated "The husband is the most important member of the family to provide support to mastectomy patient". This reveals the important role of the life partner in increasing the speed of the recovery of mastectomy parents given that during that time the patient may feel unwanted, not sexy enough and not appealing; here appears the role of the life partner (husband) in helping the patient accept themselves and start loving their bodies all over again and accept their faith. This is the same result which came up with Sandham and Hardcourt (2007) noting that breast reconstruction post mastectomy can be an upsetting background for both patients and their spouses, who might need to be required in the basic leadership prepare and to bolster their spouses. They may have data needs that are unmistakable from their spouses and may not feel ready to discuss the experience. In any case, obstructions can keep spouses from examining their sentiments and worries about reconstructive surgery. Breast reconstruction represents a few difficulties for both the patient and their spouses and further innovative work of mediation that concentrates on both the patient and her partner are required. Also, (2014) indicated that marital adjustment gets to be distinctly adequate when there is common comprehension, understanding, closeness, and convenience for each other. The example of marital adjustment between a spouse and a wife gets exasperates because of the progressions realized by the incessant ailment called breast cancer which has both physical and also mental effect.

The third variable which is the support group and its efficiency in increasing the speed of the recovery of mastectomy patients it can be read from the table above that the most influential paragraph was the 6th articulated "The hospital gives the patients the option to enroll in a support group". In that sense, it is clear that the hospital plays a role in gathering between the patient and help them share their experience with each other, the medical staff who has a direct contact with the patients realizes the importance of increasing the awareness of the patients' condition and what are the stages that they are going to face through their illness time. From that point, the hospital tries to gather between the patients and let them speak and share their feeling with one another in order for them to be aware of their disease and how to deal with it. This also was indicated by Stevenson and Coles (1998) noting to the importance of the support groups and giving the needed assistance to patients and their families in the stages that the illness my go through in addition to the influence of the information that patients may share with each other and its role in sharing knowledge and help for the family and the household in general.

The fourth variable of the study was the surgery. In this variable it is supposed that giving the patient information and explaining to them the surgical process of the mastectomy may increase the speed of their recovery. According to that questionnaire above, the sample of the study saw that "Explaining the procedures of the surgery is bound to the age and condition of the patient" and that paragraph appeared to be the most influential one of all. In that sense, many studies appeared to be in confusion between explaining the process of the surgery to the patients or leaving the medial issues for the medical staff as the patients may not fully comprehend the process of the mastectomy. It appeared through the analysis that this issue must be bound to the age, intellectuality, and condition of the patient, meaning that the doctors have the freedom to decide whether to explain the process of the surgery to the patients or not.

**Table (5): Mean and standard deviation of the variables**

| Descriptive Statistics | | | | | |
|---|---|---|---|---|---|
| | N | Minimum | Maximum | Mean | Std. Deviation |
| Body Image | 144 | 1.43 | 5.00 | 3.3581 | 1.06490 |
| Support Group | 144 | 1.38 | 5.00 | 3.2031 | .85202 |
| Family | 144 | 1.50 | 5.00 | 3.2569 | 1.01521 |
| Surgery | 144 | 1.50 | 5.00 | 3.2211 | 1.01673 |
| Valid N (listwise) | 144 | | | | |

According to the table (5) above it can be seen that the most influential variable of the set variables within the study was the body image. The issue of body image was seen to be deeply influential in speeding the recovery of the patients after the mastectomy. The reason is attributed to the fact that the body image is something so important that influences the personality and the confidence of a woman which can be seen to be one of the most important factors that individuals around the patient need to take care of. The influence of the body image starts with the woman as soon as the breast cancer appears. It hits directly the internal confidence of a woman and the way she sees her body. The influence then starts to move from the patient to her sexual partner (husband) and the influence spreads around the family with the unstable relation that the wife and the husband is going through. From that point, it is seen through the analysis that the psychological care of women after mastectomy is really important and should start with the body image and the fact that a woman should be exposed to a psychological program that enables her to accept her new body, that way the acceptance will be passed to the husband and will be spread through the whole household.

**Hypotheses Testing**

The hypotheses of the study will be as follows:

**H1**: Body image psychological framework fastens the recovery of Modified Radical Mastectomy patients.
**H2**: Support group fastens the recovery of Modified Radical Mastectomy patients.
**H3**: Family awareness fastens the recovery of Modified Radical Mastectomy patients.
**H4**: Pre-surgery knowledge fastens the recovery of Modified Radical Mastectomy patients.

**Table (6): One sample t- test**

| | N | Mean | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|
| h1 | 144 | 3.3581 | 1.06490 | .08874 |
| h2 | 144 | 3.2031 | .85202 | .07100 |
| h3 | 144 | 3.2569 | 1.01521 | .08460 |
| h4 | 144 | 3.2211 | 1.01673 | .08473 |

**Table (7): One-Sample test**

| | t | df | Sig. (2-tailed) | Mean Difference | 95% Confidence Interval of the Difference | |
|---|---|---|---|---|---|---|
| | | | | | Lower | Upper |
| h1 | 4.036 | 143 | .000 | .35813 | .1827 | .5335 |
| h2 | 2.861 | 143 | .005 | .20313 | .0628 | .3435 |
| h3 | 3.037 | 143 | .003 | .25694 | .0897 | .4242 |
| h4 | 2.609 | 143 | .010 | .22106 | .0536 | .3885 |

According to the table (7) which shows the one-sample test of the hypotheses, the first hypothesis which is articulated "Body image psychological framework fastens the recovery of Modified Radical Mastectomy patients." Appeared to be the strongest hypothesis of all, however, the table shows that all hypotheses were accepted and all the four variables appeared to be influential on speeding the recovery of the mastectomy patients.

## Conclusion

Generally speaking, the current study seeks to examine the influence of a well-built psychological program to increase the possibility of fast recovery among mastectomy patients within Al-Amal cancer center in Jordan on four different levels which are (body image, family, support groups, and surgery). The sample of the study consisted of 157 participants from the staff nurses that are available within the center and have a direct access to the patients through their illness journey.

According to the results of the study, as 144 participants answered the questionnaire properly it appeared that the most influential part which should be taken into consideration through the recovery process is the body image, it appeared that the body image is one of the most important aspects that supports the recovery of a woman after the surgery of mastectomy and helps deeply in giving a healthy approach to deal with the patients after the change that took place on their bodies. In addition to that, it appeared that self-perception (body image), unsettling influence, and lower self-empathy were connected with expanded mental trouble among breast cancer survivors.

Following the issue of the body image, there appeared that the family which took the 2$^{nd}$ rank in the influence on the recovery process of the mastectomy patients. The family as variables revolved around the sexual partner (husband) who played an important role in the process of the recovery of mastectomy patients. In this sense, it appeared that the psychological support that the husband offers in the case of mastectomy plays a very important role in the field of helping their partner go through the process of mastectomy and accept their bodies after the surgery.

## Recommendations

Based on the analysis of the study and in accordance with the conclusion the current study recommends the following:

- A patient and her life partner ought to be urged by health experts to talk about their worries about body image and sexuality at any phase along the illness stages.
- Any inabilities or incessant physical inconvenience that a lady may have ought to be evaluated by an individual from the health care team as this will affects self-perception and Psycho-social affect in the territories of self-perception and sexuality for ladies with breast cancer
- A lady's worries about her self-perception and sexuality and that of her partner ought to be surveyed by a specialist from a health care team, for example, a breast cancer nurse. Issues that might be of concern include: how agreeable a lady and her partner are in dealing with any scars or a lady's simplicity of self-perception before a mirror like how a lady feels about disrobing and presentation her body before

her partner. also, comfort in closeness or sexual cooperation and effect of malignancy on the relationship, event of menopausal indications, including hot flushes or any adjustments in sexual desire.

**References**

1. Allen, J. D., Savadatti, S., & Levy, A. G. (2009). The transition from breast cancer 'patient' to 'survivor.' *Psycho-Oncology*, *18*, 71-78.
2. American Medical Association (1989). The American Medical Association Encyclopedia of
3. Ando, N., Iwamitsu, Y., Kuranami, M., Okazaki, S., Wada, M., Yamamoto, K., et al. (2009). Psychological characteristics and subjective symptoms as determinants of psychological distress in patients prior to breast cancer diagnosis. *Supportive Care in Cancer*, *17*, 1361-1370.
4. Beatty, L., Oxlad, M., Koczwara, B., & Wade, T. D. (2008). The psychosocial concerns and needs of women recently diagnosed with breast cancer: A qualitative study of patient, nurse and volunteer perspectives. *Health Expectations*, *11*, 331-342.
5. Brothers, B. M., & Anderson, B. L. (2008). Hopelessness as a predictor of depressive symptoms for breast cancer patients coping with recurrence. *Psycho-Oncology*, *18*, 267- 275.
6. Collie, K., Bottorff, J.L., Long, B. (2006). A narrative view of art therapy and art making by women with breast cancer. Journal of Health Psychology, 11(5), 761-775.
7. Curado, M.P. (2011). Breast Cancer in the world: Incidence and Mortality. Breast Cancer in the world: Incidence and mortality: Saudi Publica Mex, 53: 372-384.
8. Delhanty, D.L., and Baum, A. (2001). Stress Breast cancer.in Baum. A, Revenson, T.A., Singer, J.E. (Eds.). *Handbook of Health Psychology.* Lawrence Erlbaum associates; Mahwah, New Jersey, London, *45,* 747-756.
9. Fallbjörk, U., Rasmussen, B., Karlsson, S. and Salander, P. (2013). Aspects of body image after mastectomy due to breast cancer – A two-year follow-up study. *European Journal of Oncology Nursing*, 17(3), pp.340-345.
10. Ferlay, J., Shin, H.-R., Bray, F., Foreman, D., Mathers, C., & Parkin, D. M. (2010). GLOBOCAN 2008 v1.2, Cancer Incidence and Mortality Worldwide: IARC CancerBase No. 10 [Internet]. Retrieved from http://globocan.iarc.fr
    Ferlay, J., Soerjomataram, I., Ervik, M., Dikshit, R., Eser, S., Mathers, C., Bray, F. (2013). GLOBOCAN 2012 v1.0, Cancer Incidence and Mortality Worldwide: IARC CancerBase. No. 11 [Internet].
11. Friedman, L.C., Kalidas, M., & Elledge, R. (2006). Optimism social support and psychosocial functioning among women with breast cancer. Psychooncology, 15: 595-603
12. Ganz, P. A. (2008). Psychological and social aspects of breast cancer. *Oncology*, *22*, 642- 653.
13. Garlick, M., Wall, K., Corwin, D., Koopman, C. (2011). Psycho-spiritual integrative therapy for women with primary breast cancer. Journal of clinical psychology in medical settings, 18(1), 78-90.
14. Giannopoulos, V.L., Vella-Brodrick, D.A. (2011). Effects of positive interventions and orientations to happiness on subjective well-being. The Journal of Positive Psychology, 6(2): 95-105.
15. Gospodarek,.R. E (2009). "The psychosocial impact of breast cancer recurrence". *Master's and Doctoral Projects.* Paper 320. Retrieved on 23rd Dec 2016 from http://utdr.utoledo.edu/graduate-projects/320
16. Hack, T.F., & Designer, L.F. (2004). Coping responses following breast cancer diagnosis predict psychological adjustment three years later. Psychooncology, 13: 235-47.
17. Han, J.Y., Shaw, B.R., Hawkins, R.P., Pingree, S., McTavish, F., & Gustafson, D.H. (2008). Expressing positive emotions within online support groups by women with breast cancer. Journal of Health Psychology, 13(8), 1002-1007.
18. Horgan, O., Holcombe, C., & Salmon, P. (2011). Experiencing positive change after a diagnosis of breast cancer: a grounded theory analysis. Psycho-Ontology, 20(10), 1116-1125
19. Kim, J., Han, J.Y., Shaw, B., McTavish, F., & Gustafson, D. (2010). The roles of social support and coping strategies in predicting breast cancer patients' emotional well-being: testing mediation and moderation models. Journal of Health Psychology, 15, 534-552.
20. Kolahdoozan, S., Sadjadi, A., Radmard, A. R., & Khademi, H. (2010). Five common cancers in Iran. *Archives of Iranian Medicine*. doi:0011 [pii]\r010132/AIM.0011.
21. Levy, S.M., & Wise, B.D. (1987). Psychosocial risk factors, natural immunity and cancer progression: Implications for intervention. *Current Psychological Research & Review. 6*, 229-243.
22. Madhumanti, M. and Sathiyaseelan, A. (2014). Marital Adjustment in Women after One Year of Mastectomy. *Global Journal of Biology, Agriculture and Health Sciences*, 3(1), pp.43-47.
23. McGaughey, A. (2006). Body image after bilateral prophylactic mastectomy: an integrative literature review. J Midwifery Womens Health, 51(6):e45-9.
24. Medicine, New York: Random House
25. Parkin DM, Bray F, Ferlay J, Pisani P. (2005): Global cancer statistics, 2002. *CA Cancer J. Clin. 55*, 74-108.

26. Parkin, D.M., & Fernandez, L.M. (2006): Use of statistics to assess the global burden of breast cancer.*Breast J. 12*, S70-S80.
27. Przezdziecki, A., Sherman, K., Baillie, A., Taylor, A., Foley, E. and Stalgis-Bilinski, K. (2012). My changed body: breast cancer, body image, distress and self-compassion. *Psycho-Oncology*, 22(8), pp.1872-1879.
28. Rabin, C., & Pinto, B. (2006). Cancer-related beliefs and health behavior change among breast cancer survivors and their first-degree relatives. *Psycho-Oncology*, *15*, 701-712.
29. Sandham, C. and Harcourt, D. (2007). Partner experiences of breast reconstruction post mastectomy. *European Journal of Oncology Nursing*, 11(1), pp.66-73.
30. Sarenmalm, E. K., Öhlén, J., Odén, A., & Gaston-Johansson, F. (2008). Experience and predictors of symptoms, distress and health-related quality of life over time in postmenopausal women with recurrent breast cancer. *Psycho-Oncology*, *17*, 497-505.
31. Schmid-Büchi, S., Halfens, R. J., Dassen, T., & van den Borne, B. (2008). A review of psychosocial needs of breast-cancer patients and their relatives. *Journal of Clinical Nursing*, *17*, 2895-2909.
32. Simard, S. & Savard, J. (March 2007). Fear of cancer recurrence inventory: Development and initial validation of a multidimensional measure of fear of cancer recurrence. *Supportive Care in Cancer*, *17*, 241-251.
33. Stanton, A.L., Danoff-Burg, S., Cameron, C.L., Bishop, M., Collins, C.A., Kirk, S.B., Twillman, R. (2000). Emotionally expressive coping predicts psychological and physical adjustment to breast cancer. Journal of Consulting and Clinical Psychology, 68: 875-882.
34. Stevenson, B. and Coles, P. (1998). A breast cancer support group: Activities and value to mastectomy patients. *Journal Of Cancer Education*, 8(3).
35. Stuart, K., Brennan, M., French, J., Houssami, N., & Boyages, J. (2006). Life after breast cancer. *Australian Family Physician*, *35*, 219-224.
36. Tomich, P. L., & Helgeson, V. S. (2006). Cognitive adaptation and breast cancer recurrence: Are there limits?. *Journal of Consulting and Clinical Pyschology*, *74*, 980-987.
37. Vahdaninia, M., Omidvari, S., Montazeri, A. (2010). What do predict anxiety and depression in breast cancer patients; A follow-up study. Soc Psychiatry psychiatr Epidemiol, 45:355-61
38. Wilson, J.P., Miller, A., & Edge, S.B. (2012). Breast Education in General Surgery Residency. American Surgeon, 78(1), 42-45. Retrieved from http://libpublic3.library.isu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=70841484&site=ehost-live
39. Wolff, S. N. (2007). The burden of cancer survivorship. In M. Feuerstein, Handbook of cancer survivorship. New York: Springer.
40. Zabora, J., J., BrintzenhofeSzoc, K., Curbow, B., Hooker, C., & Piantados, S. (2001). The prevalence of psychological distress by cancer site. Psycho-Oncology, 10, 19-28