

# The psychological impact of breast cancer assessed: the testimony of a psychotherapist and breast cancer sufferer

Cordelia Galgut

I write this article from the perspective of a mental health practitioner and academic, trained in Psychology, Counselling and Psychotherapy, who has also lived through two breast cancer diagnoses. In May 2004, then in November of the same year, in my late forties, I was diagnosed with node-negative, grade 2, ductal breast cancers; two small, hormone-sensitive tumours, one in each breast, for which I was treated with breast-conserving surgery, radiotherapy, and adjuvant therapy after the second radiotherapy.

Therefore, I have now seen life from the other side of the fence, too. No longer only the long-time professional supporter of women with breast cancer, I am also one of those women. So, what have I gleaned from my new frame of reference, that can add to our existing understanding of the psychological impact of breast cancer on women, and help us to offer the best service we can to this patient/client group?

In this article, without mentioning names, I describe experiences I have had with both medical and mental health practitioners, and their support staff, that have been more or less helpful. (I use these terms to mean medical doctors, nurses (including breast cancer nurses), medical technicians, physiotherapists, administrative staff, counsellors, psychotherapists, psychologists,

also complementary therapists working in the cancer field.) I hope that it is taken as read that I am aware that our motivation, as practitioners, for doing or saying what we do, is to help, and that anybody working in the cancer field has an incredibly difficult and exacting job. I also recognise that medical practitioners have a dual brief and their medical brief is an

arduous enough job in itself, without the added burden of having to take into account the psychological needs of their cancer patients. Furthermore, although I allude in general terms to comments made by many women I have met and spoken to, on my journey through cancer, and quote another woman with breast cancer, who has also had chemotherapy, (whom I interviewed, informally, about what she had found more or less helpful emotionally, for this article, and refer to as 'Rosie'), I recognise that this testimony is mine alone, in that I have not conducted research in this area.

#### **'Trained brain' versus 'breast cancer sufferer brain'**

Throughout this process, I have found my 'trained brain' to be in conflict with my 'breast cancer sufferer brain'. This is because my taught knowledge of psychological processes and my cancer patient experience have often been contradictory and this difference has brought me up sharp on many occasions. Though I had some notion of how theories and views, describing predicted emotional responses to extreme crises, e.g. Parry (1990:18-29) were not entirely consistent with my own (or others') lived experience, it is only through the trauma of breast cancer that I have encountered such a great disparity. This, in itself, has been somewhat unnerving for me and made me realise how unwittingly complacent and unaware I have been in the past, despite my best intentions, in my support of the

cancer patients I worked with prior to my diagnosis. Indeed, I have found the psychological impact of breast cancer to be infinitely more complex than I could ever have imagined, being alarmingly unpredictable, seeming to know no bounds: in fact, a veritable emotional rollercoaster. Therefore, I would now assert, on the basis of my experience, that it requires its own psychological definition and understanding.

*And, indeed, my 'trained brain' has learnt from my 'breast cancer sufferer brain'.*

#### **Is every woman's experience of breast cancer different?**

The predominant view among the medical and mental health practitioners I have met, as a patient or client, over the last two and a half years, has been that every woman's psychological response to breast cancer is different. This is confirmed by Brooks (2006:31), who says, 'how we deal with living with it differs from one person to another - this is my personal story', and this would have been my own view, prior to breast cancer. However, it is now my belief that undue emphasis is often placed on the individual nature of a woman's emotional journey through the disease and not enough on the commonality of women's breast cancer experience. To elaborate: individual women's cancer profiles, home situations, past life events, psychological make-up, psychological states prior to diagnosis, amongst a number of other factors, will inevitably have

an effect on how they cope with breast cancer. However, there will be common responses to, for example, the initial diagnosis, surgery, radiotherapy, etc., which can get lost by placing too much emphasis on the fact that women's responses are all different. The assumption that the latter is so might, it could be argued, result in us losing sight of the fact that there is a significant commonality of experience we need to respond to and acknowledge.



*Cordelia Galgut*

*Every woman's experience of breast cancer may be different, but there will also be many decidedly significant emotional reactions in common.*

#### **Isn't my response normal?**

It would seem, on the basis of my experience, that a certain level of emotional response to the trauma of breast cancer diagnosis and treatment is acceptable to most health professionals, and deemed normal, but that enduring anxiety, for example, is not, despite longstanding evidence to the contrary, (for example, Fallowfield et al, 1987). Anger and depression seem to be viewed similarly. All appear to be too easily diagnosed as worrying symptoms that might need treating, rather than recognised as common and normal psychological responses to breast cancer, reflected by Rosie when she said, 'They haven't coped with me having an emotional response...and people

expect you to get back to normal, as if you've had a headache or something. I was talking to B today, (her counsellor) and she said the majority of women complain about this.' Drug treatment might be appropriate, and psychological support certainly will be – it is the practitioners' attitude and approach that is important here, for example, 'Yes, this is an expected and normal reaction, is there anything we can do to help you?' In fact, this recognition is helpful, in itself, while the lack of it can make a patient feel that her response is abnormal and add to her emotional upset. I particularly remember feeling almost wrong for asking whether I was going to die when I was first diagnosed, because of the reaction that this question elicited, and subsequently for finding it hard to believe I would live for long, for similar reasons, though these are both very normal reactions when adjusting to a cancer diagnosis. Rosie expressed the same upset that I

felt at these doctors' lack of awareness when she said, 'They had no understanding. People's ignorance adds to your trauma. You feel so apart.'

Questions have arisen in my mind, more than once, such as, what then is a 'normal' reaction to breast cancer? Am I not reacting normally? I wonder whether you would react any differently in my situation? I certainly found my gynaecologist's recognition that she could not know how she would react and feel, if diagnosed with breast cancer, until she had experienced it herself, very supportive.

*What we might consider to be an exaggerated emotional response to a breast cancer diagnosis and treatment might be a totally normal one.*

### **Is the psychological impact of breast cancer different from other life traumas and other cancers?**

I have also realised, since viewing the relevant literature through 'breast cancer eyes', that, (as far as I am aware, not having done an exhaustive literature search in this area) women with breast cancer (or indeed any cancer) are often not specifically mentioned in the literature, diagnostic and otherwise, concerning crisis and trauma, but subsumed into the life-threatening illnesses category; or else alongside other victims of trauma, such as the bereaved, prisoners of war or the victims of terrorist attacks (DSM 2003:463).

These are all deeply traumatic events, but different, nonetheless from the trauma of cancer, as one specific life threatening illness. In the case of life threatening illnesses, it is the sufferer's own life that is at risk, as opposed to, for example, bereavement, when it is the death of a loved one that has to be endured. Equally, a life threatening illness is not the same in its psychological impact as a life threatening situation, such as a terrorist attack. It could be argued that it is not that one of these traumas is necessarily harder to endure than the others, they are just differently awful and will, therefore, have different, as well as similar, psychological effects. Moreover, in the case of each life threatening disease, there will be psychological repercussions in common and ones that are unlike. In the case of cancer, each different cancer will bring with it particular difficulties; treatments will differ, so distinct psychological consequences are likely. In the case of breast cancer, the added element, as opposed to other cancers, is that it is a woman's breasts, in my case both of them, so laden with inordinate significance and symbolism, sexual and otherwise, that are affected. This is confirmed by Rosie, who said, 'I've had thyroid cancer and now breast cancer and it's different. It's different treatment and it affects you in a different way, because your breasts are part of your femininity.'

This, in my opinion, makes breast cancer a very particular kind of

cancer – on a par with others, (which will have their own difficulties peculiar to them) yet different, so needing very specific consideration and understanding. Interestingly, Cancer Backup, whose literature is so widely used, does not differentiate between the emotional consequences of different kinds of cancers, in their booklet 'The emotional effects of cancer' (2004). Furthermore, even in their booklet on 'Understanding breast cancer' (2005) they do very little to differentiate between the emotional ramifications of this cancer and any other kind of cancer. Moreover, on examination, it appears that no-one involved in writing the booklet is a mental health professional, even in the broadest sense!

*However, I would argue that the psychological impact of breast cancer warrants particular attention and consideration.*

### **The symbolism of the breast in western culture**

In writing this article, I am excluding men's experience of breast cancer, although I do recognise, as well as I can, the particular trauma of this diagnosis for a man. However, I am a woman and many more women are diagnosed with breast cancer than men. (According to the Office for National Statistics, in 2003, 335 men were diagnosed with breast cancer, compared with 43,756 women.) Also, the cultural significance of breasts is different for men and women, in western

culture. For women particularly, our breasts are considered to be secondary sexual characteristics and are sexually sensitive in many cases, and associated with sex, fertility, childbirth and suckling an infant. Since they are associated with sex, bare breasts are considered indecent, not for public display, in contrast to the male chest. We learn to keep our breasts hidden, and modesty is associated with covering them up, except in certain designated areas or in private. In fact, in our society, it is still hard even to breast feed comfortably in public, or at all, sometimes.

Breast cancer is, therefore, a challenge because its diagnosis and treatment upturns all these conditioned notions and expectations. Additionally, an organ so often associated with pleasure and gentle private touch suddenly becomes the victim of a rather brutal and public attack, to which there is little choice but to consent, in order to get better: in my case, imaging, biopsies, surgeries and radiotherapy. No medical practitioner would want it to be so and it is nobody's fault, but the experience inevitably becomes this for women with breast cancer – no less so for me, even though treatments are so much better than they used to be. Also, having to expose my breasts as often, and to as many people, as I have had to, when at my most vulnerable and exposed, has been an extra ordeal. Furthermore, having one's breasts surgically cut, with degrees of disfigurement and damage inevitable, can undermine a woman's

confidence, no matter how she felt prior to breast cancer, and it is common for a woman to feel less attractive as a result of all the treatment she receives for this illness. I am no exception, and it seems that an expressed awareness of this, and recognition of this fact, is very helpful psychologically to women, as it has been for me. For example, a thoughtful comment from a consultant about the fact that I hadn't put on weight on adjuvant therapy was very considerate and validating of how I might be feeling then. Conversely, an unthinking and unnecessary comment from another consultant, about how I was 'slightly over ideal body weight', having put on a stone since I was first diagnosed with breast cancer, served to further undermine my confidence, in my physical self and generally, and was extremely upsetting at the time.

*The breast, because of its symbolism in our culture, becomes a defining part of a woman's identity, so that breast cancer is inevitably a challenge to how we see ourselves as women.*

### **I'm still the person I was prior to breast cancer**

Throughout breast cancer, I have been aware of a definition of me as a cancer patient, well-motivated, no doubt, that has seemed to require that I be this and nothing else – almost an assumption that it would somehow be better for me if, for example, my professional

persona flew out of the window, along with my intellect, at the point that I was diagnosed. (Comments from practitioners, either explicit or implied, have indicated a concern that the development of cancer and stress are linked, and that, at this time, it would be better for me to concentrate on getting better, which would be more easily achieved by, for example, not working, the assumption being that it would be more stressful for me to continue to engage my brain actively. In fact, this has not been my experience.) To be both a breast cancer patient and a mental health practitioner-academic, who wanted to continue to do face to face work, obviously with the proviso that it was ethical to do so (Galgut, 2006), and continue my academic work, has seemed an anathema to some of the medical and mental health practitioners supporting me through this period. The possibility that I could work productively and ethically, or still be capable of commenting, rationally, on what was happening to me, was lost on some, almost as though reason and emotion cannot exist, or both be given credence, side by side. In that vein, I was sometimes expected to adopt a dependent, quasi-moribund, child-like role at a time when I was already feeling sufficiently powerless and out of control, a common psychological reaction to a breast cancer diagnosis and treatment (Frankel, 1988). I do recognise that some breast cancer patients will want the professionals to take over, and certainly, I too have wanted this input at points. However, for the

most part, keeping a degree of control has been a vital coping strategy for me, as well as an expression of the kind of person I was prior to cancer, and continue to be, and I have certainly spoken to other women with breast cancer who have said likewise.

My intellect has not stopped functioning through this traumatic period of my life, even at times when I have felt least physically well and most emotionally challenged. I have remained passionately interested in furthering thinking and knowledge in my chosen field. Moreover, the experience of breast cancer has, along with many negative impacts, provided me with the positive of fuelling my interest in improving the quality of service we offer as practitioners, an area I had already researched and written about. The existence of this persona, and its maintenance through breast cancer, has been enormously supportive of me psychologically at a time when, as is common (Cancer Backup, 1:17), my self confidence, self-image and self-esteem have taken a real knock. Recognition that one's brain doesn't just stop working when diagnosed and treated for breast cancer, (indeed, sometimes, in my case, it has overworked) and that we remain all of whom we were prior to diagnosis, would have been very helpful for me at this time. Also, for me personally, encouragement to keep all parts of me alive, rather than the reverse, would have been very beneficial, too.

*A woman with breast cancer is still, in every sense, the woman she was prior to diagnosis.*

### **The 'us' and 'you' divide**

The health professionals and support staff I have found most emotionally supportive and who have afforded me the most comfort during my most difficult times, have been those who have risked aligning themselves with me, in some sense. They have done this either by stating explicitly, or by conveying through their behaviour, an awareness that their situation could be mine – that, as human beings, we are all at risk. With these professionals, the 'us' and 'you' divide has been less present, even though they have had a job to do. These people have also been sufficiently aware of the complexity of their own thoughts and feelings about cancer to be able to risk engaging with me with warmth and humanity.

*Breast cancer patients might well appreciate an expressed acknowledgement of their health professionals' shared humanity.*

### **'It'll get easier as time goes by'**

From diagnosis through to the present day, I have been the recipient of a myriad of comments whose aim has been to reassure me that a cancer diagnosis would get easier for me psychologically over time. Actually, I would maintain that things change over time, rather than get easier. In some ways, they seem to get harder. There also appears to be a common

misconception that you move in a fairly linear way through a variety of post-trauma stages: for example, from shock, denial, depression, grief and mourning, through to acceptance, and to err from this is somehow abnormal – indeed my own training taught me this. Prior to cancer, I had, broadly speaking, taken this approach in my own work with people in crisis, and it has been something of a surprise to me, as I referred to earlier, that I have not followed the ‘correct’ patterns myself, even though I had been aware that the process was not as clearly defined as this. My reactions have been contradictory, unpredictable and rather frightening at points, and there seems to have been little significant discernible linear emotional progress. So how have I reacted at various stages? What has been the psychological impact on me of my diagnosis, surgery, radiotherapy, adjuvant therapy?

### **From diagnosis to the present day**

Overall, what strikes me about my psychological process through breast cancer that I could not have predicted prior to experiencing it, is the multi-layered and cumulative nature of my emotional responses, their inter-relatedness, the variations in their intensity and the contradictory nature of them – all in all, their enormous complexity.

### **Diagnoses and surgeries**

My first diagnosis did not happen in the way I would have imagined

or wished. I was not directly told I had cancer, despite longstanding research data which suggest that the way in which the surgeon conducts the ‘bad news’ consultation, i.e. informing the patient of the diagnosis and treatment options, can have a major influence on short and long term psychological outcome. (Fallowfield & Baum, 1989)

My first diagnosis was, in fact, a lesson in how not to treat a woman in this situation. I realised something was wrong, simply because I was left in the waiting room until everyone else had been seen, then was told I needed another mammogram. When I finally saw the radiologist, she was unfriendly and had, seemingly, no awareness of my rising panic and appeared singularly incapable of engaging with me. I, in fact, had to ask her if I had cancer, to which she responded, ‘Well, at least it’s not lung cancer!’ She refused to answer my subsequent questions and asked, at one point, whether I was a scientist or medical doctor. No emotional support was offered. I was just expected to go home and come back to see the surgeon the following week. When I insisted on seeing a doctor to talk to me explicitly about the strong possibility that I had breast cancer, which I had gleaned was as clear as it could be on the mammogram and ultrasound of the suspicious area, and from the radiologist’s comment, I was treated as though I were being difficult and making an unusual request. The doctor I eventually saw was also,

seemingly, unaware and unconcerned about my psychological state at this point.

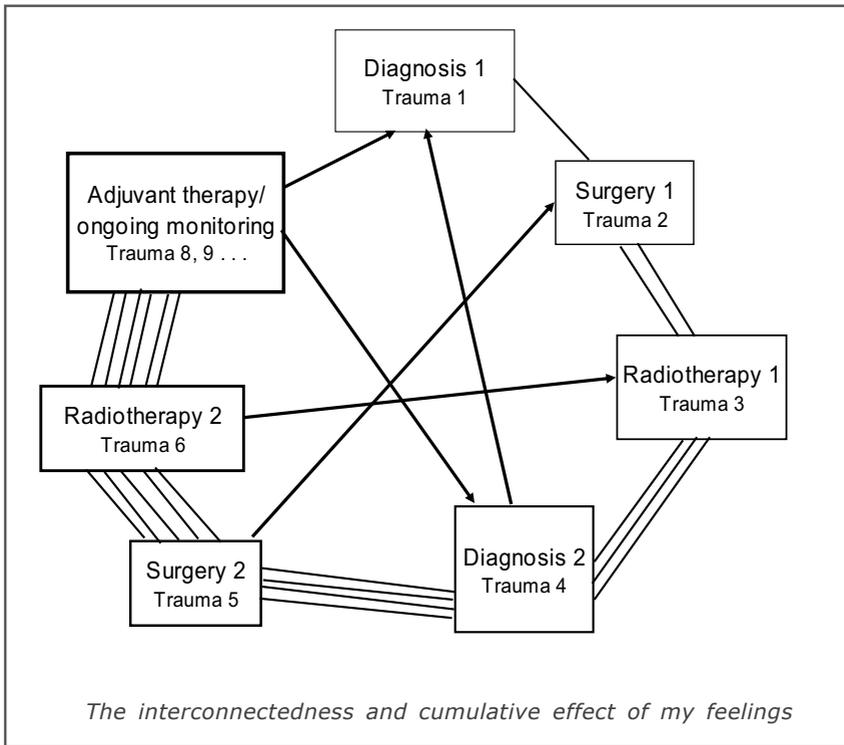
Throughout that initial phase, my emotional response was seen as unreasonable. I was quickly defined as 'naughty' and 'difficult' by my first surgeon, for expressing any feelings about what was happening to me, and he appeared unwilling to view me as an equal in any sense, as just another person, but one who happened to have been diagnosed with breast cancer. Similarly, asking questions was taboo, despite established research that indicates that a 'poorly informed patient is more likely to be an anxious patient' (Fallowfield et al, 1987:696). Indeed, he then referred me to one of the two oncologists working with him because she was good with 'emotional' patients! It was only when I met this oncologist, a few weeks after my first diagnosis, that I was treated with any kindness, humanity and understanding or offered any emotional support. This was a total relief and enormously validating of my inevitably rocky emotional state, during what was, undubitably, an overwhelmingly gruelling time for me, as for any woman in this situation.

The contrast between the way my first diagnosis was handled and my second could not have been more pronounced. It was my oncologist, on this occasion, who gave me the bad news. Again, she did everything she could to support me at this time, incorporating a real awareness of how I would be feeling into the

way she handled the situation. This helped enormously and the memory of it acted as an ongoing support for me. This approach was particularly crucial because it became apparent that my second tumour had probably been there at the time of my first diagnosis, but not discovered, and this has inevitably had an impact on me emotionally. (At the time of my first diagnosis, both breasts had had mammography. The affected breast had been ultrasounded over the suspicious area, but not elsewhere, and not the other breast. Five months later, a 0.9 cm tumour could be seen clearly in my other breast on ultrasound, though I was told at the time that my mammogram was clear.)

Also, in sharp contrast to my bad experience with my first surgeon and his radiologist, my experience with my second surgeon and the radiologist with whom he works was, thankfully, much more positive. Not only was I listened to, and my questions welcomed, but I was treated with kindness, understanding and concern; also by his medical secretary. This approach made all the difference to how I coped with the extra ordeal of more surgery, and to my challenged emotional state during this period. With this in mind, I remember particularly appreciating this surgeon visiting me regularly, during my stay in hospital, and taking the time to sit down and talk to me in an engaged and supportive way.

Indeed, that which characterised my emotional reaction, after my first diagnosis and surgery, was



the start of a chain of emotional reactions and states, complicated for me, no doubt, by my second diagnosis and second course of radiotherapy, during which, for example, I could feel disbelief and a degree of acceptance of what had happened at the same time. My training had not equipped me for this, nor had my previous life, prior to cancer, which had thrown up many contradictory thoughts and feelings simultaneously, but nothing on this scale. Each time I embarked on a new phase, for example the second surgery after the second diagnosis, or my second course of radiotherapy, I was re-traumatised by that

event, and catapulted, it seemed, into an even more complicated and unnerving emotional state, connected not only to the one I was experiencing at the time, but to memories of the previous trauma and the ones before that. This re-traumatisation then served to make it harder for me to cope emotionally with the next trauma, a kind of layer upon layer emotional impact, so that at points, I could hardly bear another piled on top of the previous one, (see diagram). Moreover, the complexity of my psychological response was such that I suffered a bottomless pit of intense emotions, the like of

which I had never experienced before in my life, despite the fact that I had lived through some very difficult times prior to cancer.

### **Radiotherapy**

My first and second radiotherapies were very positive experiences, in the sense that my oncologist continued to be exceptional in her commitment to giving credence to the psychological consequences of what was happening to me at different stages, as well as looking after me medically. This approach helped enormously and provided me with invaluable support through a hugely challenging phase in my treatment, and ultimately made the emotional impact of a very bad skin - and generalised physical - reaction to radiotherapy much more tolerable. The input of breast care nurses was also helpful at this time.

Certain aspects of radiotherapy can be very emotionally gruelling. Indeed, I have heard women say that it is psychologically harder than it is physically. The root of some of these difficulties lies in the exceptionally vulnerable position a woman has to lie in, on a radiotherapy table, day in, day out for several weeks. She needs to be put in an uncomfortable position, from which she must not move or her treatment will be jeopardised. This is, through no fault of anybody's, a defenceless position: the woman's arms are up above her head, she is lying

flat on her back and her breasts are bare. Also, she has to be on her own in a room, whilst the treatment is completed, and she is surrendering, because she knows she has to, to a dose of radioactivity. In my case, I felt as though I had to override every natural impulse not to subject myself to what felt like an assault, though clearly no assault was intended. Rationally, I knew it was necessary, but I had to consciously cross every boundary I had regarding my physical and emotional safety, to surrender myself to the process.

Furthermore, consenting to putting myself in such a vulnerable position, knowing I had no real choice, triggered disturbing memories for me, as for other women to whom I have spoken. This possible psychological impact of radiotherapy is seldom spoken of, and there seems to be no mention of it either, in, for example, Backup booklets that pertain to radiotherapy to the breast or its emotional effects, or any research data in this area, that I am aware of. There were, however, a couple of occasions on which I felt this very acutely, and became tearful on the radiotherapy table, exacerbated by the fact that I was already badly burnt, and submitting to more treatment felt like a kind of self harming, though I knew it was necessary. I believe this emotional reaction to be common, confirmed by one of the counsellors who supported me at a later stage. Many women have been sexually harassed, raped or sexually abused. 21% of women in the

UK have been the victim of child sexual abuse (Cawson et al, 2000). Studies have also shown that up to one in four women in the UK has suffered rape or attempted rape (Painter, 1991). By the law of averages, significant numbers of women having radiotherapy will have experienced one or more of these ordeals, and an increased awareness amongst medical and mental health practitioners that radiotherapy can trigger traumatic memories for women, as well as be traumatic in itself, would be very welcome. Also, a willingness to state this possibility openly, prior to treatment, might well be helpful, contrary to what one might think. I for one, despite my psychological savvy, had not anticipated this possibility. At the time, I was too overwhelmed by everything that was happening to me.

### **Life post-cancer and on adjuvant therapy – the last eighteen months**

In some ways, this period has been the hardest for me, as it seems to be for many women. It has been at this point that, for example, my shock response has really kicked in. This has been something of a surprise, since my training had encouraged me to think that someone in my situation should have been getting beyond this by now, not starting to really feel this emotion.

It is during this post-cancer period that I have encountered my lowest moods, having been depressed at points, inevitably I would say, as the 'no choice' element of my situation has sunk

in. However, I have also put pressure on myself not to feel so bad, and this learnt tendency in me has been exacerbated by my own, and some health professionals', mistaken assumption that because my treatment was conservative and my prognosis good, I should not be lingering in this way, emotionally. In fact, this has been the stage during which the real uncertainty of my situation has really hit home, good prognosis or not. I have found myself having monumental difficulty imagining that I might live for any length of time. The commonality of this reaction is confirmed by Fallowfield et al (1987:699) who say, 'The patient treated conservatively for early breast cancer clearly has a plethora of emotional problems to face. We cannot assume that preserving a woman's breast will in itself protect her from anxiety and depression. She still has to cope with the knowledge of having a life-threatening disease with an uncertain prognosis.' Indeed, Fallowfield et al found that slightly more women who were conservatively treated experience heightened long term anxiety and depression than women who have had mastectomies.

In fact, only very recently have I started to re-discover some rather fragile equilibrium, which can, nevertheless, be very easily rocked. My rational brain kicks in with the facts of my case, but my emotions, my fear and terror, run away with me fairly easily, exacerbated by the fact that I realise that the aetiology of cancer is neither simple, nor is its course fully understood.

In many ways, this has been the period during which I have needed the most support. Therefore, reasonably regular meetings with my current oncologist and surgeon are still important, and help me cope with my ongoing fears about possible local recurrence or metastases, as they provide me with an opportunity to be monitored face to face and check out things that are concerning me at that time. The counselling I continue to have, both cancer-focused and general, is invaluable, supportive and validating of these difficulties and how normal they are, as is support from complementary therapists, for similar reasons. However, fairly frequently, medical practitioners, perhaps understandably, have been less comprehending of the sometimes increased intensity of my emotions and less cognizant of the reasons why I might be presenting in this way.

During this period, I have also experienced an increased fear of mammograms and ultrasounds, as each time I re-live the trauma of my first and second diagnoses, and face the terror of a recurrence, not least of all since, for me, that would mean mastectomies and, possibly, chemotherapy. So, contrary to what one might expect, although the routine is more familiar now, it does not get any easier emotionally. Fallowfield (1989:5) says, 'However trivial the follow-up visits might be to clinicians, it is an extremely anxious time for the patient. Many experience considerable distress contemplating a feared recurrence which will be an early

sign of impending demise.' Moreover, in some ways, the further away I get from my last diagnosis, the more I have invested in clear scans. With this in mind, I experienced my second surgeon's recent acknowledgement of the psychological ramifications of having a second breast cancer, discovered so soon after the first, very validating of my fears about local recurrence and associated worries.

I started to take hormone therapy one and a half years ago, and the impact this has had on my emotional state has been extremely marked and it has taken me quite a while to adjust, specifically, to having my ovaries switched off. Medical, mental health and complementary practitioners have all helped me cope, during my worst times. However, the repercussions, both physical and mental, of being catapulted into the menopause cannot be underestimated – though its full impact has, in my experience, been less well-recognised by some of the practitioners I have met than certain aspects of, for example, radiotherapy or chemotherapy proper.

The myriad of emotional and physical side-effects I have faced may have been more extreme than those experienced by some women. However, they are also known to be common side-effects, suffered by many in this situation, and deemed very debilitating, not least of all, for example, loss of libido, one consequence whose psychological impact can be fairly devastating. Moreover, in

my experience, this is often either a taboo subject, (as, it seems, is anything pertaining to the influence of cancer on sexuality) or is attributed more to post-cancer psychological trauma than to hormone therapy. From my point of view, the more open and creative medical professionals can be about an issue such as this, its causes and effects, the more supported I feel. I acknowledge that some women will not want to talk to their doctors (or other health professionals) about these matters. However, there does seem to be evidence that women do not disclose their feelings to doctors because they feel guilty about their reactions to treatment, (Fallowfield et al, 1987) rather than because they really do not want to talk about them.

A number of other factors have influenced my emotional state during this period, that are obviously peculiar to me, though I believe that most women will experience some similar complications. For example, health issues have emerged, both related and unrelated to my hormone treatment, that have been stressful in themselves, as well as triggering, for example, cancer-related fears in me, all of which serve to further complicate the complex psychological impact of breast cancer.

To this day, I struggle with degrees of shock and disbelief, about what has happened to me, along with a rather tenuous, growing, though not linear, acceptance. Like many women in my situation, life will never be the same again; what was normal is no longer and will never be again.

Life is now about re-definition and continuing to find ways to live with what has happened to me. I am aware that, psychologically, the process is nowhere near over, is ever-changing, confusing and, in some sense will never be complete, but, like Frankel (1988:725), I take strength from Nietzsche who said, 'Whatever doesn't kill you makes you stronger'; to some extent, so far, this has been the case for me.

### **For each disease its own cure**

In conclusion, I would suggest that, although much of the input from very committed and caring medical and mental health practitioners has been of great help to me, the foremost issue I have raised in this article, namely the need to recognise the particular psychological needs of breast cancer patients, needs further discussion and consideration. As Brooks (2006) says, 'Often the psychological aspect of breast cancer is not considered a high priority by health professionals. Although this is understandable when their focus is on clinical issues, it should be an integral part of the overall care.' In order to help achieve a greater degree of this, I believe that more qualitative research in this area should be prioritised, focusing on the experiences and perceived needs of women with breast cancer themselves. Then and only then, will we have enough relevant knowledge to be able to offer the most appropriate psychological support to the unfortunate, and growing numbers of, women diagnosed with this disease.

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