Mastectomy: The Male Partners' Psychosocial Dilemmas and Coping Processes

Thea Diste Wilson

1986

MASTECTOMY: THE MALE PARTNERS' PSYCHOSOCIAL DILEMMAS AND COPING PROCESSES

A dissertation submitted to the
California Institute for Clinical Social Work
in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
in Clinical Social Work

by

THEA DISTE WILSON

June 1986

©

1986

THEA DISTE WILSON

ALL RIGHTS RESERVED

THE CALIFORNIA INSTITUTE FOR CLINICAL SOCIAL WORK

We hereby approve the dissertation

Mastectomy: The Male Partners' Psychosocial Dilemmas and Coping Processes

by

Thea Diste Wilson

candidate for the degree of
Doctor of Philosophy in Clinical Social Work

Doctoral Committee

Sylvia Sussman Chair	Ph.D. title	5/8/86 date	Sylvia Sussman signature
Martha M. Millhone Committee member	Ph.D. title	4-25-86 date	Martha M. Millhone signature
Ralph E. Johnson External member	Ph.D. title	4/29/86 date	Ralph E. Johnson signature

This study is dedicated to
my mother, Marie Schuback Diste, whose
unconditional support and encouragement
sustained me throughout the dissertation process

and in memory of

my father, Theodore Diste, whose exceptional
parenting enriched my life.

ACKNOWLEDGEMENTS

I want to express my sincere appreciation to the twelve men who generously shared their perceptions of the mastectomy experience and to the members of my dissertation committee who so willingly gave of their time, energy, and experience.

Dr. Sylvia Sussman, chairperson of my dissertation committee, masterfully advised and guided me from the onset of the study to its conclusion. Her challenging ideas about the research design and method of investigation added important dimensions to the study at each phase.

Dr. Martha Millhone, committee member, offered me the benefit of her extensive theoretical knowledge as well as a very broad shoulder.

Dr. Ralph Johnson, external committee member, spent many hours critiquing my research proposal and dissertation. His objective assessments helped shape the final form of the study.

I want to thank my family, friends and colleagues for enduring my overcrowded schedule, abbreviated holiday celebrations, and countless weekends in the library.

ABSTRACT

Much research on breast cancer and mastectomy overlooks the male partner's integral role in a woman's adjustment to her breast loss. This study focuses on the basic psychosocial issues and dilemmas facing men during the sequential phases of the mastectomy process, and on how they perceive their role in that process.

Self-report data were obtained through semistructured, in-depth interviews with nine men whose long-term relationships remained intact after their wives' surgery. Through content analysis of the interviews, themes and patterns were identified and abstracted. The data analysis shows that the men faced common issues at each phase of the experience and used common coping methods to deal with their own intense feelings while "being there" for their stricken partners. The study describes those issues and coping strategies as well as the roles the men defined for themselves. The findings also reveal that the men shared a philosophical perspective about "how we made it through" that gave meaning to their experience and enabled them to integrate it into their lives. The findings suggest that a solid and committed preoperative relationship can generally withstand the difficulty of adapting to this major life crisis.

Coping theory offers the theoretical context for understanding the data. Implications for community and clinical services and future research are presented and discussed.

TABLE OF CONTENTS

APPENDIX A

APPENDIX B

APPENDIX C

APPENDIX D

LIST OF TABLES

Table Page

CHAPTER I

INTRODUCTION AND PURPOSE

Men's psychosocial responses to their partners' breast cancer and mastectomy have long been neglected. Interestingly, male physicians usually diagnose this female illness; yet, paradoxically, these same physicians often relegate the male's role in his partner's health crisis to a vague, shadowy background. It is as if men and their feelings are unimportant and irrelevant when their partners are undergoing highly crucial physical and psychological losses, losses that often result in death.

Only within the past decade have men's attendance and participation in the delivery room and their active sharing of neonatal and early parenting been encouraged. Yet, the acceptance of the male partner's significance is still tentative. For example, the July, 1982 issue of the American Journal of Orthopsychiatry contains a paper, "The Forgotten Grief: A Review of the Psychology of Stillbirth"; focusing on the loss and mourning experienced by the potential mother and "parents," it omits specific mention of what this loss might have meant to the potential father.

Cursory attention has also been given to male responses to menopause, hysterectomies, and abortion. An article in Time magazine (September 26, 1983), which describes the refusal of 45 affiliates of Planned Parenthood to participate in sociologist Arthur Shostak's study on men and abortion suggests one reason for this. The affiliates refused on the basis that the study would "upset women," be a "threat to women's autonomy," and "ultimately raise moral qualms about abortion" (p. 78).

Similarly, the counseling provided by rape crisis centers has often bypassed the importance of the male partner's unique dilemma of guilt, confusion, and outrage, as well as his potential role in his partner's return to prior patterns of adaptive functioning.

Breast cancer is the second leading cause of cancer deaths among American women (lung cancer is first). According to the American Cancer Society's 1984 statistical predictions, one out of eleven American women will develop cancer of the breast sometime during her life. It is among those life-threatening illnesses grouped as "women's health problems." This study, however, takes the position that breast cancer is not only a woman's health problem, but a family problem, because it threatens the stability of the entire family's interactions.

Over the past ten years, awareness has grown of the psychosocial and physiological traumas most women experience before and after a mastectomy. Many recent and current studies reflect the urgent need for research designed to help women cope with their breast losses. These studies have examined the breast cancer patients' fears of death, disfigurement, and mutilation of their bodies; of loss of both social and self-esteem; and of male rejection and impaired sexuality. However, almost none of the current literature on the subject addresses the male partner's psychosocial responses (feelings, behavior, attitudes) to the mastectomy. Because his response is an integral factor in a woman's recovery process, it is essential to address this issue.

The research presented here was undertaken for that purpose. The central questions being asked are: What are the basic psychosocial issues involved in men's responses to their partners' mastectomy process, and what role do male partners take in that process? This qualitative study is based upon analysis of self-report data obtained in semistructured, in-depth interviews with nine men whose partners had had a mastectomy. The interviews gave the men an opportunity to talk about their feelings and experiences relating to their partners' surgery. They explored how these men dealt with the crisis of their partners' potential and actual loss of a breast(s), the threat of her death from breast cancer, and the process of her convalescence, grief, mourning, and reparative adaptation.

The primary significance of the study is that it will teach us more about the role of men in the mastectomy process and about its impact upon them. By deepening our understanding of their experiences, the study should (a) enable us to more adequately provide needed services, (b) alert and sensitize other professionals about the concerns of male partners as the "hidden" victims of breast cancer, and (c) make suggestions for future investigation.

An important focus of this study is how the men dealt with themselves and the world around them during a specific life crisis. Once the men's basic common issues and problems were identified through the data analysis, their efforts to cope and adapt to the experience became evident. The loss of the breast itself was less of an issue than expected. Coping theory provided a context for understanding what these nine men thought and did to meet the demands of the stressful event in order to integrate the experience and move on with their lives.

The dissertation will be presented as follows: The second chapter examines the mastectomy literature and the historical and psychosocial issues it raises. The third chapter describes the research design and the method of investigation. The fourth chapter presents an analysis of the interview data in terms of the phases and issues of the men's experience: how the subjects attempted to resolve the issues within each phase, and how prepared they were for the ensuing phases. The fifth chapter addresses the men's coping and adaptation strategies. Coping theory and research will be presented as a conceptual framework. The sixth chapter summarizes and discusses the findings and their implications.

CHAPTER II

REVIEW OF MASTECTOMY LITERATURE

Since the early 1970s, research on women's psychosocial responses to mastectomy has proliferated. Studies have covered numerous topics, ranging from the increasing number of choices of breast cancer treatment and breast reconstruction to sexual intimacy issues and appropriate psychotherapeutic treatment modalities. The literature reveals an increasing emphasis upon releasing breast cancer from the same societal closet in which we have stored child molestation, wife abuse, the unemployed homeless, and other contemporary social concerns. Whether a result of the women's movement of the seventies, the "sexual revolution" of the sixties, or the entrance of more professional women into the research arena, mastectomy no longer is solely a "woman's problem." The surgery has a domino effect, extending to the partner and the entire family, and thus necessitating further understanding of its effect upon primary loved ones.

Testimonials such as Betty Rollin's First You Cry abound in the popular psychology literature, while the visual and printed media have made the country aware that the capricious nature of breast cancer does not discriminate on the basis of race, religion, or economic status. By discussing their surgeries on national television and in newspapers and magazines, prominent women such as Betty Ford, Happy Rockefeller, Shirley Temple Black, and Julia Child have joined the ranks to educate women about regular breast self-examination and early detection.

However, little has been written about men's responses to mastectomy, and what exists is limited in scope. In fact, only one published study focuses on men's reactions to their partners' mastectomies: Wellisch, Jamison, and Pasnau's 1978 study, "Psychosocial Aspects of Mastectomy: II. The Man's Perspective." Yet even this study resulted as a counterpart of their preceding study, "Psychosocial Aspects of Mastectomy: I. The Woman's Perspective."

Women's breast cancer literature provides the historical context from which documentation of the male partner's integral role is emerging. This literature makes clear that we need to further probe the male perspective of mastectomy by asking the men themselves about their particular problems and dilemmas. This review of the literature consists of three parts, moving from the general to the specific: (1) Social and Cultural Significance of the Breast in American Society; (2) Historical Overview: Emerging Recognition of the Male Partner in the Mastectomy Experience; and (3) Psychosocial Problems and Issues Confronting Male Partners.

Social and Cultural Significance of the Breast in American Society

The female breast has been an object of intrigue throughout recorded history, and the literature is replete with references to it. Franklyn (1976) noted, "The breast has been adored, worshiped, venerated, sanctified, glamorized, glorified, and exalted by every tribe, every race, and every social sect known to living man" (p. 5). Significant in prehistoric society as a symbol of nature's fecundity and a mythical connection between nature and survival, the breast in modern American culture has become an erotic object. Small (1978) observed, "Although interest in the female breast is universal, particularly in Western European civilization, some anthropologists claim that perhaps no other society is so obsessed with the bosom than the American culture" (p. 2). Mead (1949) concluded that the female breast had become so idealized in this country that it had become symbolic of a woman's identification with the feminine role. An essay on female beauty in _Time_ (March 6, 1978) stated, "Breasts have been strapped down, cantilevered up, pushed together or apart, oiled, and siliconed" (p. 54). _Playboy_ editor Robert Wilson wrote in 1974: "The brassiere, in fact, has been designed and redesigned so often that it will do virtually anything, depending on the demands of the fashion of the moment" (p. 73).

This obsession with the female breast in our partriarchal society has had a profound effect on women. Small (1978) wrote:

> There is an obvious effect of this breast emphasis on the woman and on the developing girl. Physiological changes of puberty necessarily interact with cultural values and psychological factors which will influence the developing woman's adaptations and functioning as a woman. Girls are usually aware early in pubescence that the appearance of their breasts is an important criterion of the desirability and acceptability as a woman. The cultural importance given to female breasts has resulted in a woman's desirability being frequently measured by the size and shape of her breasts. Whatever the actual physical state of her breasts, each girl, interpreting her own unique development, is subliminally influenced by the societal expectations regarding shape and size.
>
> The woman may receive the message that a larger breast infers greater feminity. Advertisements for brassieres capitalize on this myth. Plastic surgeons are well-occupied with women who are unhappy with themselves because they feel their breasts are too large or too small, often in terms of their perception of what society deems acceptable. (p. 4)

Psychoanalytic theory has added another dimension to our attempts to explain the mystique of the breast. Several of the developmental theories have focused on the instinctual attraction of the newborn for its mother's breast. Gorman (1964) noted:

> Comment on the cathectic content of the image of the breast has undergone the vicissitudes of the instinct theory. In The Interpretation of Dreams, Freud reflected that 'love and hunger meet at a woman's breast,' and elaborated the concept that the breast is the first object. Winnicott felt that mother's breast represents the activities of mothering, and Bowlby asserted that sucking and therefore primal suckling is one of five basic instincts. (p. 23)

Weiss (1975), focusing on the effects on the male, added:

> The warmth and security of the breast is a deeply ingrained sensation. Perhaps the first direct contact a boy has with a female is with his mother's breast. Some psychoanalysts suggest that this, in part, explains the fascination with the female breast. (p. 56)

In his review of Freud's theory of infantile sexuality in _Childhood and Society_, Erikson (1950) described the oral sensatory stage of development:

> The infant's inborn and more or less co-ordinated ability to take in by mouth meets the breast's and the mother's and society's more or less co-ordinated ability to feed him and to welcome him. At this point, he lives and loves with his mouth; the mother lives and loves through her breasts. (p. 72)

Most of the psychological and sociological theories offered to describe the American obsession with the breast as an erotic object also focus on our cultural attitudes and influences. For example, Small (1978) wrote of the emphasis American men place on the female breast:

> While males in other societies may be more focused on buttocks, legs, thighs, or genitalia, American men place value on the female breasts. They, like the female, are also taught that femininity and sexual desirability are equated with having breasts. It is not uncommon for men to discuss women among themselves in terms of how well-endowed the women are. Magazines such as _Playboy_ capitalize on this factor.
>
> How much the American male's interest in the female breast is cultural and how much is biologically based is still unknown. Kinsey reported that the sight of the female breast is a greater stimulus to the male than that of the female genitalia. Sexual behaviors are acquired through general sociopsychological learning. (p. 5)

In Societies where the female breast is uncovered and unfettered, men basically ignore the bosom. Some sociologists have suggested that our society's emphasis on concealing the breast only increases its allure. Many pubescent American males eagerly scan issues of National Geographic for a glimpse of the forbidden, bare object under the guise of gleaning information for seventh-eighth grade social studies projects. Weiss (1975) submitted:

> The breast has been a veiled subject, and perhaps for that reason, fascinating. All cultures, even primitive ones, cover the primary sex organs as a protection against constant sexual arousal. As a result, there is a displacement of interest from the vagina to other areas, upward to the breasts, downward to the legs, and backward to the buttocks. Often the secretive qualities increase the interest. Depending on various past experiences and associations, men will focus on different secondary centers. (p. 16)

As women are assuming a more equitable role in our society, the breast is becoming less idealized and confined, more free and natural. In the late 1960s, many women stopped wearing brassieres as a protest against sexual stereotyping. The women's movement resulted in a decade of unprecedented social, political, and economic change for women, and by extension, for society as a whole. These changes not only affected our cultural and sexual attitudes, but also led to a sobering redefinition of femininity in our culture.

It is evident from the literature that a mastectomy can have many physiological, psychological, and culturally-determined effects on a woman. However, in light of our breast-oriented society's historical view of the female breast as a woman's badge of femininity, a source of love-play and arousal, of security and comfort, it is also evident that there is still little known about the effects of a mastectomy on the male partner.

Historical Overview: Emerging Recognition of the Male Partner in the Mastectomy Experience

This section will begin with a brief description of the major medical or surgical treatments for breast cancer developed over the past ninety years, and will then survey the psychological research that led to recognition of the impact of cultural and psychological factors and interpersonal relations on mastectomy patients. In the process, focus will be placed upon the emerging recognition of the male partner's role in the mastectomy experience.

Lewison (1981) described breast cancer as "an ancient and elusive disease which has claimed its many victims throughout the world and from time immemorial" (p. 3). Although there have been significant medical advances in the treatment of this old and dreaded disease since Halsted's nineteenth-century development of radical mastectomy procedures, Lewison observed, somewhat pessimistically: "Despite our ever improving diagnostic acumen and surgically therapeutic skills, the mortality rate has remained essentially unchanged over the past fifty years" (p. 3).

Dr. William Halsted, the father of radical mastectomy, developed his surgical procedures for performing breast amputations in 1894. The significantly higher survival rates evidenced by radical mastectomy patients resulted in the continued and almost exclusive use of this extensive and mutilating surgery for over fifty years. However, in conjunction with the twentieth-century discoveries of radiation therapy and chemotherapy, the "modified" radical mastectomy (1948) and other less extensive and disfiguring surgical procedures began to be performed on patients in whom no auxiliary nodal involvement was detected (The Breast Cancer Digest, 1980).

Because the exact etiology of breast cancer is still unknown, and controversy continues over the best methods of treatment, it is not surprising that the major research thrust has combined medical concepts from the histological, biological, and biochemical disciplines. Breast cancer research has concentrated on finding the elusive cure while simultaneously working to prolong the patient's life both through early detection and treatment and through minimizing the chances of cancer recurrence.

Not until the late 1940s and early 1950s, however, did researchers become committed to the psychological aspects of mastectomy. At that time, with psychoanalysis and Freudian symbolization flourishing in this country, the medical profession was beginning to recognize the interrelationship among psyche, soma, and environment.

In 1951, in Boston, Finesinger, Cobb, and Abrams initiated a pioneering project in applied psychiatry, "Psychological Mechanisms in Patients with Cancer." After two years of interviewing cancer patients, they were convinced that "much of the experience gleaned from dealing with psychiatric patients is of potential value in the care of patients with diseases commonly supposed to be wholly outside the province of the psychiatrist" (p. 1159). They identified and illustrated the most common mechanisms of defense employed by the cancer patients they had studied: Denial, suppression, dissociation, identification, regression, conversion, and sublimation. They were the first psychiatrists to describe the psychological dynamics of the cancer patient-physician relationship.

At the same time that the Boston group was studying the psychological defenses and behavioral responses of cancer patients, Renneker and Cutler's team of psychoanalysts and surgeons (1952) were conducting a milestone exploratory study. By examining the reciprocal relationship that existed between the then-current breast surgery treatment methods and applicable psychoanalytical knowledge of behavior, they were the first to recognize the cultural and psychological ramifications of breast cancer. They formulated two major psychological meanings of the breast to a woman. First, within our culture, they acknowledged that breasts are sexually significant: "They are the only positive evidences of femaleness, as the reproductive organs are internal and the pubic area is smooth and concealed" (p. 834). Second, they noted a universal significance of breast: "The other major meaning of the breast lies in its function as a milk bearing organ. . . . There remains an unshakable and universally unconscious symbolic connection between the breast and motherhood" (p. 834).

Renneker and Cutler (1952) not only equated mastectomy in the female with the castration complex in the male, but were among the first researchers to recommend the husband's preoperative and postoperative involvement. Although they addressed the husband's personal feelings and responses generally rather than specifically, they did recommend that the husband's aid be "enlisted privately":

> He should be instructed to be particularly tender, loving, and attentive pre and post operatively. He should play upon her feminine charms through hospital gifts of clothes, cosmetics, and other items calculated to refocus her attention on still-present points of feminine pride. (p. 835)

Even though they reflected the sexist attitudes of the fifties with such statements as "any past feminine achievements--husband and children--should be recognized with the patient" (p. 835), they were among the first to refer to the postoperative fears a woman experiences about her husband's potential rejection, the importance of the husband's reassuring role during his wife's postoperative adjustment, and the future of the relationship in general (Renneker & Cutler, 1952).

About the same time, a New York research psychologist, Morton Bard (1952), observed that "regardless of the adaptation a patient achieves in attempting to resolve her feelings about the total (mastectomy) experience, support and understanding by her family have an enormously significant role" (p. 1146). Reflecting his times, he further observed that many women perceived their bodies as indicators of their worth in interpersonal relationships:

> These women related to their husbands through physical attractiveness and when they felt their bodies had been made ugly by radical mastectomy, profound feelings of self rejection could develop. Even if the husband actually remains affectionate and supportive, the patient may feel she has disrupted the relationship and stands in danger of losing him as a result. When this occurs, the lack of self esteem is projected as the husband's attitude despite his actual expression of feeling. (p. 1146)

Although much of the literature during this time relegated the male partner to the group of supportive family or friends, Bard and Sutherland (1955) singled him out: "We feel that any discussion of radical mastectomy must include the role of the husband, as the operation may constitute a real threat to the marriage" (p. 669). In referring to his then-unpublished work with Dyk, "Impact of Cancer Surgery on the Family," Sutherland noted: "It has been shown that post operative marital relations are usually contingent upon the pre operative status of the marriage" (Bard and Sutherland, 1955, p. 669). Bard and Sutherland were also the first author-researchers to advocate referral to a family counseling service if the relationship began to deteriorate following the surgery.

Almost a decade later, in 1963, Quint, a research nurse specialist, was among the first of her profession to make an appeal for more professional services for mastectomees. While working in a university hospital, she had initiated a study in which she had observed, both preoperatively and postoperatively, the adjustments of 21 Caucasian women to breast surgery. After observing the women for more than a year after their operations, she concluded: "The major problems they faced alone--not because family and friends lacked concern or did not try to help, but usually because the latter were also caught up in the tragedy and made impotent by it" (p. 90).

As a result of a growing awareness about the difficulties most mastectomees experience in adjusting to their breast losses, researchers in the 1960s began to explore the psychoemotional responses of women to amputation, including changes in self-image resulting from the breast loss. Goffman (1963), although not concerned with mastectomies as such, pioneered the study of stigma and physical disability and of the relationship between the loss of external organs and body image. Schoenberg and Carr (1970) correlated the mastectomee's adaptation to her changed body image with the way she had resolved other significant losses. As with the loss of a limb, they concluded that the loss of a breast is symbolically experienced as the death of a body part and that it psychologically compares with the loss of a significant person. This concept was corroborated by Wabreck and

Wabreck (1976), who determined that the reaction to the loss of a breast is identical to that of the loss (by death or divorce) of a loved one. In focusing on the woman's need to mourn for her breast loss just as she would for any other significant loss, these studies alert both patient and partner to the normalcy of a mastectomee's alternate periods of depression, grief, anxiety, and anger.

By 1970, some researchers had begun to shift their focus from a woman's individual reactions to the assault on her body and her self-esteem toward the sexual and relationship dimensions. Since then, mostly due to the growth of the study of psychodynamics in both theoretical conceptualization and clinical practice, the role of the male partner has become more clearly defined and pronounced. Recognition of the intricate emotional, communicational, and cognitive elements inherent in close human relationships has elevated men to a major supportive role in their partners' adaptation to breast loss. For example, Ervin (1973), a surgeon, advocated that the male partner be included in the decision-making process both before and after surgery to provide the female's needed continuity of partnership. He postulated that although the emotional recovery depended mainly on the inner resources of the patient, it also depended greatly on the support extended by her partner, family, and friends.

Maguire (1978) followed 75 mastectomy patients under 65 years of age for a year after surgery. He reported that they described significantly more sexual problems than did a control group of benign breast tumor biopsy patients. Maguire found that one in three of those women who had had an active and satisfactory sex life before the operation had either ceased to have any sex life or any enjoyment from it 12 months later. Only 8% of the benign group (50 women) experienced similar problems (pp. 50-51). May (1981), recognizing that sexual partners are often confused and apprehensive about the sexual implications of mastectomy, pointed out that the partner's reaction is just as important as the woman's reaction.

Witkin (1979) stressed the importance of communication between partners through her description of what she labeled the mastectomy "bind." In this "bind," the woman, fearing rejection, waits for the husband/lover to assume the sexual initiative, while the husband fears he will do something "wrong" and upset or even hurt his wife. Despite the fact that each desires physical and emotional closeness, their hesitation in approaching each other leads to avoidance and withdrawal. Metze (1978), who refers to this as the "vicious cycle," states that "the feelings mastectomees have about themselves are often projected onto the husbands, then these women blame them for their reactions" (p. 28).

Regina Kriss (1982), a researcher in behavioral science at Stanford University, was quoted in the *New York Times* following a conference film presentation based on her patients' mastectomy experiences:

> Nobody knows how mastectomy affects a man in terms of sexual desire. It's a confrontation with death, illness and aging. I think it inhibits sexual desire. Men won't admit how affected they are. They feel terrible about it and they are saddened by it, but they may be physically turned off by it. (New York Times, March 1, 1982, p. 138)

Reach to Recovery is the American Cancer Society's visitor program. For the first time in its 30-year history, the program's 1982-83 packet of materials for mastectomy outreach volunteers included a letter designed for the mastectomee's male partner. This letter, which was the American Cancer Society's first official recognition of the male partner's role in a woman's recovery process, listed options available to help him deal with his particular concerns. It said in part:

> Recovery varies with the individual. We know this period of physical and mental adjustment is helped by large doses of love and understanding. The key is the demonstration of that love and understanding in the same familiar ways. . . . Changing behavior now, however subtle, might be interpreted as a rejection. She is adjusting to the changes in her body. Her doubts and fears are to be expected.
>
> It is sometimes difficult to understand how deeply she may feel that her femininity has been threatened. . . . Talk with each other . . . share your apprehensions and concerns . . . try to be open and candid.
>
> You may wish to talk about the disease, its treatment, and her recovery with her doctor. If you have questions you would like to discuss with someone who has been through this experience, please contact the ACS office. A number of Reach to Recovery services are available, including meeting with another man who has helped the woman in his life. (ACS Volunteer Materials, 1983)

This letter was a positive step forward in that it addressed the need for both partners to adjust to the woman's physical and psychological loss. A comparison between this letter and Renneker and Cutler's 1952 "instructions" to the male partner reflects the changes in attitude of the past 30 years. The letter addressed the female's fear of rejection and her need to mourn, and recognized that the male may have feelings he needs to explore and clarify with another male who has been through the recovery process. Yet, although stressing communication, the American Cancer Society's letter failed to address concerns about sexuality and intimacy, particularly the mutual apprehension both partners might experience about attempting to resume or achieve sexual responsiveness and emotional closeness.

Thus, although the mastectomy literature preceding the 1940's dealt almost exclusively with the medical or surgical treatments of breast cancer, it now reflects the increasing recognition by researchers of the male partner's integral role in a woman's recovery process. However, even with this growing awareness, few empirical studies have investigated the perceptions, attitudes, and concerns of men about their partners' mastectomies.

Psychosocial Issues and Problems Confronting Male Partners

The breast surgery literature discussed in the preceding section illustrates the emergence of the male partner's recognized role in mastectomy recovery. The literature reviewed in this section focuses more specifically on the psychosocial issues confronting the man and on how he might adapt to them. Particular attention is given to the significant findings of the one exploratory study that has been published to date.

As a result of their clinical observations, several authors have addressed the male's initial emotional reaction to his partner's mastectomy. In 1955, Bard and Sutherland attributed rejecting reactions to the projection of the male's own fears of illness and amputation. "In some instances, the husband may be appalled by the wound itself because of the meaning body injuries or wounds have for him. He may have had life-long fears of illness, operations, or even phobic reactions to body injury" (p. 669). Schoenberg and Carr (1970) later observed that when a man's anxiety over mutilation is great, "He is likely to react to his wife's mutilation with avoidance or repulsion" (p. 127). Comfort (1978) stated: "Men may be profoundly disturbed by the altered curves, as well as by the anatomic changes involved" (p. 224). Although he observed that men may "be irrationally rejecting, denying rejection, or simply projecting their own embarrassment," he concluded that "male reactions are often more concerned and reticent than rejecting" (p. 224).

Significant as these clinical observations are, it was not until a study by Wellisch, Jamison, and Pasnau (1978), "Psychosocial Aspects of Mastectomy: II. The Man's Perspective," that evidence of the male partner's actual emotional concern was established through systematic research methods. Wellisch et al. (1978) reported: "The reality of the man's emotional involvement is evident in all cases, a finding that cannot be ignored by medical and mental health professionals involved in contact with this population" (p. 545). They continued, "The man is anything but a detached observer, even if he takes a seemingly distant, uninvolved stance" (p. 546). Although Wellisch et al. (1978) emphasized that their study was a limited exploratory investigation into an extremely complex area requiring larger, more random samples of men from more varied socioeconomic and ethnic backgrounds, it deserves recognition as the first, and as yet the only, published study to examine men's reactions through the application of scientific procedures.

The study sample consisted of 31 men; 30 were married and 1 was cohabiting. The age range was 34 to 74 years, with a mean of 54.4. Half of the sample was obtained through contact with spouses who attended meetings of a self-help mastectomy recovery group (a parallel study was simultaneously undertaken to study the psychosocial aspects of mastectomy from the woman's perspective). These women were given test materials for their partners and themselves; all tests were returned through the mail. The other subjects were recruited with the assistance of the American Cancer Society (ACS). The ACS contacted women who had both undergone breast surgery within the past five years and indicated that their husbands were willing to participate. Each of these husbands was then sent a questionnaire consisting of eight pages of open - and close-ended questions concerning his perceptions of various aspects of his own and his partner's emotional and behavioral status before and after the mastectomy. Three psychological instruments were included in the packet sent to each subject: the Locke-Wallace Marital Adjustment Test, the Rotter Locus of Control Scale (I-E), and the Eysenck Personality Inventory (EPI). These psycological measurements revealed that the sample was generally stable and extroverted.

The return rate for the questionnaires was approximately 15%. Two reasons for this low response rate may have been the lack of personal contact and the sheer bulk of the questionnaire. Because of the small response rate and because the group was mainly Caucasian (94%), many were Jewish (36.6%) and most were economically stable ($20,000 mean annual income) with at least some college education, the authors concluded that their findings "be viewed with some degree of caution." They stated that this group "may represent the extremes at both ends of the response continuum, and may not reflect the characteristics of a less potentially biased, more heterogeneous group of spouses of mastectomy patients" (p. 545). Furthermore, although the authors do not elaborate on the point, only men referred by their wives participated in the study. This underscores the researcher's difficulty in gaining direct access to male respondents to study their reactions to mastectomy.

The overall results of Wellisch et al.'s (1978) study revealed that "a sizeable proportion of the 31 men either coped well with their partners' mastectomies or denied their psychological stresses" (p. 545). The authors pointed out, however, that a smaller subgroup of this sample "was distressed, remains distressed, and reported a downward spiraling of the quality of their relationship" (p. 545).

In probing multiple aspects of the psychological, psychosomatic, and sexual responses of these men to mastectomy in their female partners, several key areas were examined. These included each man's degree of involvement in the presurgery decision-making process, his psychosomatic reactions following the surgery, his anxiety about the initial viewing of his partner's naked body after the surgery, his assessment of the sexual and intimate relationship before and after the mastectomy, and his attitudes toward breast reconstruction. The remainder of this section will elaborate upon the major study findings while offering other significant theoretical and observational viewpoints.

Wellisch et al. (1978) reported that the presurgical decision making process appeared to be important for men as well as for women, with 56.6% of the men viewing themselves as involved "to a very considerable extent" or "to quite an extent." The other 43.3% saw themselves as involved "only very little" or "not involved at all." In retrospect, 73.3% wished they had been less involved, and 23.3% wished they had been more involved. The data showed those men who thought their relationship emotionally satisfying to be highly involved in the decision-making process. Because almost a quarter of the sample wished in retrospect that they had had more involvement, the authors suggested that these men might have felt they had "no right" to such involvement and could not or should not trouble the physician for increased inclusion. Therefore, because many men will not take the initiative, the authors concluded that the physician should make the effort to form a relationship with the partners of female patients.

Based on their clinical experience, two clinical social workers, Green and Mantell (1978), also encouraged the male's collaborative involvement in the decision-making process, primarily because such involvement would help dilute the sense of helplessness in both the man and his partner. They regarded this as the beginning of a shared process that facilitates adaptation to the woman's changed body image. They also rebuked the medical profession for their preoccupation with the physical treatment of the disease while neglecting the psychological concerns that emanate from the diagnosis. Harrell (1972) added: "To save a woman by surgical intervention and then deny the emotional support necessary to form a different life style and accept an altered body image is a contradiction in terms" (p. 676).

Other than general psychological references to preoperative anxiety and postoperative confusion and ambivalence, previous writings had made no attempt to explore the psychosomatic reactions of men after the mastectomy diagnosis. Wellisch et al. (1978) reported that psychosomatic reactions frequently occurred in the male partner and tended to be expressed from the time of the surgery until the woman's return home from the hospital. A significant 40.0% of the sample reported sleep disorders and nightmares. Eating disorders were less frequent, with 26.7% reporting loss of appetite and 6.7% reporting increased appetite. Overall, 42.8% of the sample indicated that their work performance was "adversely affected" during this time.

Wellisch et al. (1978) found that one of the most crucial areas probed by their study was the male's anxiety about the initial viewing of his partner unclothed after the surgery. Although their questionnaire was not structured to assess whether the men who had not seen their partners unclothed had refrained from doing so out of their own or their partner's preference, 6 of the 31 men (nearly 20%) had not so viewed their partners. However, some of the written comments by the men ("I cannot bring myself to look at her operation and she has been careful not to show it to me"; "Am not looking forward to eventual occasion"; "Will eventually do this by mutual agreement, want the wound to heal somewhat") suggest that the decision not to look at the incision site is often the man's choice. The authors, noting that "this contradicted the traditional explanation of how such relational impasses materialize" (Wellisch et al., 1978, p. 545), concluded that a pattern of nonviewing may originate with the male rather than the female partner. They recommended that a "standard desensitization program" be initiated in the hospital--both partners could view the operation site, and the male partner could assist with changing the dressings. They felt this might alleviate some of the anxiety and negative reactions of both partners while still in a setting offering support personnel.

Wabrek and Wabrek (1976) recommended that the male partner be taught by the nurse to change his partner's dressings. They observed the male partner's fears about the healing process: he was afraid that if he slept in the same bed with his partner he might inadvertently hurt her by touching the traumatized area; yet if he slept in a separate bed, she might interpret his action as not wanting to be near her, which would only magnify her fear of rejection. Like many other health professionals in the 1970s, they advocated the use of trained professionals to intervene and initiate candid discussions of sexual and intimacy concerns that have been traditionally ignored by the medical establishment.

Green and Mantell's clinical work has led them to similar conclusions:

> Partners may be as distressed as the woman when initially either viewing the incision site, the flat or concave chest, or touching the scarred tissue. A partner is often unable to cope with a mastectomee's distorted body image until after the shock of the unveiled mutilation. Willingness to look at the scar can represent a turning point in the partner's adjustment to mastectomy. Recognition that the woman no longer has an intact body may facilitate integration of the phantasy and reality of the trauma. In addition, a partner's readiness to express negative feelings about the scar and disfigured body ultimately may foster a postive self-concept in the woman. (Green & Mantell, 1978, p. 198)

Over one-third of the men in the study by Wellisch et al. (1978) indicated that "sexuality and intimacy in their relationships had been severely stressed and often negatively altered after the mastectomy" (p. 544). These findings stand in contrast to those in the parallel study of psychosocial aspects of mastectomy from the perspective of 41 women. In this similar study, 76% of the women felt their loss of a breast either made no difference or had a positive effect on their sexual satisfaction and/or their ability to be orgasmic. Further, 71% of the subjects felt their husbands' reactions to the surgery as "either very understanding or extremely understanding". However, the authors pointed out that many of the women who made such positive comments may have been using more denial than the women who reported they had substantial problems in dealing with themselves and/or their spouses after the surgery. More than a third (35.9%) reported their tranquilizer use had increased after the mastectomy, 15.4% reported their alcohol use had significantly increased, and 14.6% had sought professional help for mastectomy-related problems (Jamison, Wellisch, & Pasnau, 1978).

In the male study, when the men were asked about the impact of the mastectomy on the sexual relationship, 64.2% rated it as "no influence at all" or "somewhat for the good," while 35.7% rated it as "bad" or "somewhat bad." Wellisch et al. (1978) reported: "This finding correlated significantly with the general evaluation of the relationship; the higher the men's evaluation of the relationship, the less negative influence they attributed to the mastectomy" (p. 544). Men who had held a positive view of the relationship before the surgery tended to be positive about it afterward, while those who had held a negative view tended to become more negative.

Perhaps the fear a woman experiences about rejection by her male partner after breast surgery contains sufficient truth to warrant further consideration and investigation of the male perspective. The Wellisch et al. (1978) data clearly demonstrate that a solid and emotionally rewarding preoperative relationship generally transcends the man's adaptational problems concerning the changes in his female partner's anatomy. In his 1978 master's thesis study, "Spouse Attitude Toward Mastectomy," Nichols found that the wife's physical and emotional adjustment after a mastectomy was directly related to the husband's acceptance of her new body image. Nichols interviewed fifteen couples. Nine couples completed individual questionnaires; six couples completed questionnaires and participated in oral interviews. The couples ranged from 39 to 63 years of age; the postsurgery time span ranged from 6 months to 20 years. From his conclusions, Nichols wrote:

> From the comments volunteered by the couples within the personal interviews and the questionnaires, the couples feel their relationships (marriages) were not jeopardized by the mastectomy. Many couples stated they felt their marriages had improved after the surgery.
>
> The results revealed that the wives were more concerned about their physical health and welfare, but that they were also concerned about their post-mastectomy appearance and the acceptance of their changed body image by their husbands. Yet the husbands indicated that they were more concerned about their wives' health and welfare than with the social or sexual issues. Based upon these findings, it can be concluded that the husbands in this study were accepting of their wives' new body image and were able to offer emotional support and understanding in the process of physical and emotional recovery. (p. 59)

Wellisch et al. (1978) also discussed their findings on the man's attitude toward breast reconstructive surgery. Since 1968, the development of postmastectomy breast reconstruction has created another option for mastectomees wishing to return to their approximate presurgery appearance. This implantable silicone gel prosthesis has been sought by about 5% of the mastectomee population (Snyderman, 1978). Although many people believe women seek this surgery primarily to please their partners, the Wellisch et al. (1978) data reveal that while most of the men (87.7%) in their study had heard of breast-reconstructive surgery, their opinions on it differed. The data showed 13.3% to be very favorable, 20.0% somewhat favorable, 33.3% neutral, 6.7% mildly opposed, and 26.7% strongly opposed. The authors indicated that "a large portion of the men were quite negative and felt they had experienced enough surgery, doctors, and hospitals" (p. 546). They reported that another group of men in their study would concur if their wives insisted, "but showed little spontaneous interest." They concluded: "Only a few men strongly favored reconstructive surgery for their female partners" (p. 546).

To summarize this section of the literature review, most men have been considered only as providers of emotional support for their partners during the mastectomy process; little or no attention has been given to the personal experience of the male partner. The study by Wellisch et al. (1978) indicated that while the majority of men in solid relationships wanted to be involved in the decision-making process, they often felt confused about their "right" to be included in this major women's illness. Furthermore, these men were often unaware of the kinds of grieving responses the female was likely to experience. These data also revealed that most of the men experienced specific psychosomatic reactions while their partners were hospitalized, that they were not usually the major initiators of breast-reconstructive surgery, and that most did not wish to abandon the relationship (although most did acknowledge the anxiety the amputation placed on the sexual and intimate aspects of their relationships). All of these data point to the need for more research concerning men's experiences, feelings, and attitudes about mastectomy.

CHAPTER III

METHOD OF INVESTIGATION

Introduction

The present study focuses upon the patterns and processes of a human experience about which little is known. The central research questions were: What are the basic psychosocial issues involved in men's responses to their partners' mastectomy process, and what role do male partners take in that process? Clinical interview techniques were used to gain self-reflective data. The interviews gave respondents an opportunity to discuss their experience in their own words and thus within the context of their particular socioeconomic, psychological, and cultural frameworks.

It was expected that a common structure would be found that would encompass individual experiences. The research process was first to elicit and then to identify recurring themes in the men's experience and finally to describe the organizing structures underlying those abstracted patterns.

Although the central research questions, the methodology, and the data-collection approach provided an open system for understanding the data from the subjects' points of view, the study did begin with some assumptions.

These evolved from the literature and from a framework of theory and clinical experience that incorporates the principles of psychoanalytical developmental psychology, more commonly called ego psychology, and object relations theory. The assumptions were:

1. The mastectomy experience had involved each man in an intensely absorbing process, a life crisis that had affected his personal integration as well as his conjoint relationship.

2. During certain stages, different aspects of the experience had been felt more keenly, different kinds of coping had been called for, with some resolution occurring. In other words, the experience was expected to have a natural history; a common structure was anticipated, which the study sought to identify.

3. Psychological issues relating to loss, grief, and mourning would emerge from the data; issues relating to secondary loss (identification with a loved one's primary loss) would offer additional insights into the grief and mourning process.

4. The data would illuminate the extent to which this group of men had been influenced by cultural values placed on the female breast.

5. Insight would be provided into the ways these men adapted to their partners' breast loss. The assumption was made that the men had been able to adapt, and that coping patterns would be evident.

Research Design

Semistructured interviews were used to reveal the men's experiences through the process of induced self-reflection. The study's aim was to attain a description of the organizing structures that could serve as a basis for understanding what the men go through and how they integrate such a crisis into their lives. The issue of causation was not involved. A further goal was to generate hypotheses for more precise studies of larger samples.

The method used was both comparative and qualitative. Comparative method is a "search for commonalities and differences; the classification of such; an elaboration of the bases for classification, e.g., the organizing structures..." (Sussman, 1984, unpublished essay, "The Study of Structures"). Glaser and Strauss (1967) elaborate on this, describing the "constant comparative method," in which sampling furthers the comparative method and the generation of theoretical material. This means beginning the analytic process on the initial data (that is, beginning analysis in the data-gathering phase, weaving the two together). In the case of this research, the first interview was studied (see Analysis section for description of procedures), and the information gleaned was incorporated into the next interview, which was also analyzed immediately; this time the analysis included comparison with the previously collected data, and so on. This process continued until a pattern was established that clarified the essential quality of the experience both for research purposes and for delineating supportive treatment or service modalities. It was expected that variations and differences would illuminate, rather than distract from, the emerging patterns.

The method was also qualitative in content: "...based upon the given and shared meaning, or the way things hang together, rather than cause and effect" (Sussman, op. cit.). The men were asked what such a crisis experience meant in their lives, how they defined and coped with it, and if they learned and moved on or were set back by it.

It was expected that the interviews, along with inducing the men's memory of their experiences, would be experiences in themselves, allowing the men to reflect upon the events in new ways and thus attain perspective.

The methodological aim of this type of study is: first to establish what was happening (from the subjects' points of view), how they felt, what they did about it, and how they feel about it now; then to pull out the more abstract issues, the common themes and the organizing structures of this shared experience. Finally, an interpretive thought process links the emergent organizing structures with the investigator's expectations and the relevant knowledge and theory.

Validity and Reliability

As in any history, the subject told about his experience from his present perspective, and so the data were different from what would have been obtained if a study had been done during, rather than after, the experience. This situation in no way invalidates the information, as long as we realize that the research focused on the structure of an experience viewed with some distance from, and with some degree of personal integration of, the crisis. How these men organized their experiences during the interview in itself described a coping process.

In the course of the interviews, the subjects defined their own meanings. The interview was designed to ask about the same experience from many different perspectives, thus providing its own reliability check. This procedure was not unlike that used in surveys and standardized tests wherein the same question is asked over and over in different ways. It is purposeful that the information is subjective; the structure of the interview and the analysis of the data were designed to be as objective as is possible in any research on human beings. Abraham Kaplan, in his 1964 book, The Conduct of Inquiry: Methodology for Behavioral Science, discusses the above issues, as well as the similarities and differences between the problems in this type of research and those in more quantitative and experimentally designed research.

Procedures

Sampling

The data consisted of interview material from nine subjects chosen because: (a) They were the partners of mastectomees in the female group most susceptible to breast cancer, (b) they reflected as broad a range of socioeconomic backgrounds as recruitment procedures permitted, and (c) they fit the criteria set up for this study (see below). The purpose of such a sample was not to generalize, but to begin to establish what significant psychosocial issues were embedded within the structure of this highly stressful experience (Polkinghorne, 1983). With such a goal, the qualtity of subjects is not an issue. The data generated by the interview process was voluminous; all of the data was used. Each interview represented a sampling of how this person talks about the experience at hand. The interview continued for about one and a half hours, and the same experience was discussed from various perspectives and within a framework that changed as the interview progressed (through the establishment of rapport). Thus, the interview provided a large and varied sample of information about how the subjects relate their perceptions of this experience.

Because the study concentrated on a description of organizing structures rather than a description of cause and effect relationships between populations (Polkinghorne, 1983, p. 270), the sample consisted of exemplar rather than random cases; variables were controlled only in relation to the subjects' shared experience. It was anticipated that seven to nine men would be interviewed, with additional subjects being added until a pattern was established (Glaser & Strauss, 1967, "constant comparative method" discussed above in Research Design). Nine men provided enough data to establish a pattern, a pattern also evident in the data from the three men interviewed in the pilot study.

Criteria for Selection

The sample was chosen according to criteria felt to be relevant for this study, though recruitment difficulties made flexibility necessary regarding some of the initial specifications. The criteria and initial specifications were:

1. A length of time since mastectomy of two or more years. Those female partners would have had sufficient time to work through their grief and mourning process. In turn, the male subjects would have had enough time to reflect on their roles in that process. Men whose partners' surgeries were too recent (six months previous or less) would probably still be dealing with reactive crisis aspects of the experience.

2. A length of relationship (marriage or cohabitation) at time of mastectomy of five or more years. Such duration denotes a committed relationship.

3. A female partner whose age at the time of mastectomy was between 35 and 50. The sample would thus include partners of women in the target group most susceptible to breast cancer. According to *Cancer Facts and Figures* (1983), the risk of breast cancer increases with age. Under 30 years, the risk is minimal, but accelerates as women approach their forties. "Breast cancer kills more women aged 40 to 44 than any other disease" (*The Breast Cancer Digest*, 1980, p. 4). The 1984 edition of *The Breast Cancer Digest* reported:

> In the United States incidence rises rapidly in the two decades prior to menopause; after age 50 (which correlates roughly with menopause) incidence continues to increase, but more slowly, to and beyond age 80. (p. 2)

Although variables such as education, employment, and ethnic and religious backgrounds were not controlled, efforts were made to enlist subjects from a broad social, economic, and cultural range. However, because this was a difficult-to-reach population requiring multiple recruitment approaches, the sample was homogeneous, representing middle-class white males (see Description of Subjects, chapter IV). The same situation occurred with the pilot sample.

Due to recruitment difficulties, the sample criteria were stretched in three cases that still fulfilled the intent of the criteria. One man was included whose wife was 52 years old, as the 35 to 50-year range of high incidence was only a rough estimate, with women in their fifties who had not completed their menopausal cycles still at high risk (The Breast Cancer Digest, 1984, p. 2). Another man was included who had been married four rather than five years, because the relationship had existed more than a year prior to the marriage. This man's partner was only eight months beyond surgery. However, he was expected to be enough beyond the acute crisis aspects to meet the study's intents and purposes. The findings show that his responses were similar to those of three men in the subgroup of those "close to" the first surgery. The dividing point separating the men "close to" and "distant" from first surgery was 3.5 years. The differences between the subgroups will be discussed in chapter IV, Description of Subjects.

Recruitment and Accessability

Along with contacting recognized service providers such as the American Cancer Society, early recruitment efforts included nontraditional strategies for publicizing the study within the community. These included contacting the manager of a local mastectomy boutique that fits women for their prostheses after surgery, consulting with the first and only male Reach to Recovery volunteer in the community, as well as describing the purpose and rationale of the study at a first-of-a-kind swimwear and lingerie "fashion show" originated to meet the needs of mastectomees.

The three pilot subjects were referred by their partners following an appeal for respondents at the above-mentioned "fashion show." The audience consisted of over a hundred women, including both recent mastectomees and those whose breast amputations had occurred years before. A surprising number of women (twenty) were responsive, but time restraints allowed brief exchanges with only seven. These women were asked to discuss the proposed study with their partners. A week later, these women were contacted by telephone. If their partners had agreed to the interview, they were sent a letter (appendix A) describing the intent and purpose of the study. Within ten days, each potential subject was telephoned in order to set up an interview time at his convenience. All seven of the men telephoned were willing to participate. Besides the pilot subjects, three of the seven were placed "on hold" for the main study, while the seventh subsequently moved out of the geographical area.

During the next six months, the groundwork was carefully laid for further recruitment of subjects. Networking strategies included the following steps:

1. Individual appointments with the coordinators of cancer service programs, including the American Cancer Society, Reach to Recovery, and Encore. The purpose of these meetings was both to explain the intent and significance of the study and to enlist the assistance of key resource personnel.

2. Verbal presentations and appeals for respondents to groups of mastectomees, including a Hispanic group of cancer patients and their families, the YWCA-sponsored Encore program for post-mastectomees, and a second annual "fashion show" for breast amputees.

3. Individual contacts with professional colleagues and personal friends.

4. Recruitment articles submitted to both Encore and Reach to Recovery newsletters.

The majority (five) of the subject referrals came from professional and personal colleagues and friends. Only two men were referred as a result of the newsletter articles, although this recruitment effort reached the largest number of mastectomees. Personal contact with potential subjects or their partners generated a larger number of referrals than the more impersonal written appeals for respondents. The eighth and ninth subjects were referred through contacts made with the female partners at the above mentioned "fashion shows."

Although the women in the Hispanic group were interested in and supportive of the study, they doubted that their partners would be willing to talk to an "outsider." When three potential male subjects were subsequently contacted by telephone, they cited "too much work" or other external responsibilities preventing them from participating in the study. This response emphasizes the cultural difficulty of recruiting minority men for a study involving revelation of feelings, responses, and attitudes in a sensitive area of investigation. Also, the researcher's gender may have contributed to the men's resistance.

Attempts were made to recruit black subjects, but contacts with a black discharge nurse and a black nursing instructor, who was also a Reach to Recovery volunteer, did not result in any referrals.

To summarize: The recruitment of subjects involved both a lengthy and diverse process of recruitment efforts. Male partners were difficult to reach, as there was no structured network available through which direct contact could be made. Hospitals, physicians, and service organizations are governed by confidentiality policies that preclude their providing access to subjects. Therefore, researchers interested in this population need to develop innovative approaches, or seek early, approved access to a specific program focused on mastectomees and their families. Personal contacts and community visibility through verbal presentations and "word-of-mouth" communication proved more effective than newsletter or written appeals for this study.

The Interview

The in-depth clinical interview was chosen as the method of data collection for the following reasons: First, it provides a means of learning from the subjects themselves. "The researcher is the learner working from an agenda of questions about which the subject is the teacher" (Hancock, 1981, p. 38). The interview becomes an interactional process between the subject and researcher in which "they evolve a set of understandings rather than 'answers'" (Hancock, p. 38). Second, "These methods examine empirical reality not with a preexisting set of instruments or theoretical categories, but rather with an openness that allows categories to emerge from the observation of the natural system under study" (Blumenfeld, 1983, p.29).

Third, the interview method dignifies and ensures respect for this sensitive area of human experience as well as for the subjects themselves. The sensitive topic areas and related probe questions in this study included: reactions to the discovery and diagnosis of the tumor; the hospitalization, surgery, and recuperative processes; communication and support systems; the quality of the relationship before and after surgery; the sexual and intimate relationship; personal support systems; previous loss/illness/death experiences; and the subjects' views of women's basic fears pertaining to mastectomy. Fourth, the clinical interview allows for the possibility of restorative integration on the part of the male subjects. Thus, not only does this method enable the researcher to discover what the subjects are thinking and allow for the emergence of categories grounded in experience, but it also dignifies the experience and may prove beneficial to the subject as well as to the researcher.

John Madge (1965) wrote of the interview in The Tools of Social Science:

> We now come to the principal application of the interview in social science; that is, its use for the purpose of making people talk about themselves.
>
> The interview--and its half brother, the questionnaire--is popularly regarded as the method 'par excellence' of social science. After all, it is argued, what social scientists are interested in are people, and if you want to find out something about a person, surely the best way is to ask him or one of his friends. (p. 162)

In the Wellisch et al. (1978) study of men's psychosocial responses to mastectomy, one of the factors in the low response rate of 15% may well have been the sheer volume of the questionnaire (eight pages of open-and closed-ended questions plus three standardized psychological instruments). The inherent flexibility of the semistructured interview is that it offers each man an opportunity to talk about himself in his own words; it elicits affective aspects of the subjects' responses while allowing the interviewer to keep track of specific areas of concern.

The researcher's role in the interview process is to encourage subjects to talk about their experiences by asking a number of open-ended questions. The respondents are invited to talk freely and spontaneously, while the interviewer attempts to facilitate, clarify, and expand the personal and social context of the subjects' experiences. In this study, because each of the taped interviews lasted an hour and a half, much planning had also gone into providing the same comfortable, permissive, and nondistracting neutral setting for all the interviews.

The men were cooperative, if not eager to discuss their experiences. Each man, in his own way, seemed appreciative of the chance to "tell his own story." When asked, they all responded that they were comfortable with a female interviewer. Because most of these men were referred by their partners, it was anticipated that some would focus upon the positive ways in which they had supported their partners, perhaps minimizing their own personal pain. Conversely, it was also anticipated that some might have been referred because their partners felt negatively about their caring abilities and hoped they would be "sensitized" through the interview experience. However, all of the men were extremely candid about their positive and negative feelings concerning both themselves and their partners throughout the mastectomy ordeal. They described the stresses placed upon their relationships as well as their attempts to achieve a strengthened unity.

Within a cultural, sociological, and psychological framework, the semistructured interview guide was developed through a cumulative process. This process included pilot interviews that were conducted to refine the final interview guide.

The Pilot Study

Nondirective interview guidelines (appendix B) were pretested on three men who met the sample criteria. The guidelines consisted of four general topic areas based upon internal, external, historical, and reparative/integral aspects of the experience. In addition, the men were encouraged to raise their own special areas of interest and concern. These inclusive topic areas were culled from the relevant mastectomy literature and from information provided by colleagues, physicians, nurses, and other resource persons involved in the delivery of cancer services. Listening to the interview tapes and taking annotated notes resulted in the emergence of major themes from each of the broad topic areas and from overall interview summations. These themes primarily related to the men's basic fears of their partners' death, concern for their partners' emotional and physical recoveries once they survived the surgery, the men's efforts to define their roles in their partners' recoveries, and sexual and intimate adjustments. These themes were incorporated into the design of the semistructured interview guidelines used in the main study.

The pilot study was significant in two important ways: (a) It helped generate specific topic areas from general areas of inquiry, and (b) it enabled the interviewer to adapt to the differences between a research interview and a clinical one.

Analysis

Although flexibility is the major advantage of the semistructured interview procedure when collecting self-revealing data, that same flexibility becomes the major shortcoming when the data is ready to be analyzed, because the interviews differ from subject to subject and lack standardized comparability.

After reviewing a range of content analysis procedures developed by such social scientists and communications specialists as Hollis (1967), Gottschalk (1969), Tripodi (1980), and Hancock (1981), a content analysis schema was planned that incorporated aspects of Glaser and Strauss' (1967) constant comparative method of qualitative analysis. This schema begins with the preparation of a set of coding forms for each interview (appendix D). These forms were organized according to the broad areas of inquiry in the semistructured interview guide (appendix C). The data analysis process included the following steps:

1. Each subject's taped responses were coded and analyzed immediately following the interview, forming a basis of classification according to the broad topic areas. Starting with the first interview, information that was not anticipated was duly noted. Thus, each subject's unexpected comments, reflections, and points of view required expansion of the interview guide in some topic areas, modification in others. The relevant flexible changes in both the structure

and focus of the interviews were controlled by the interview guidelines and time restraints.

2. The interviewing procedures continued until a pattern began to emerge describing the central themes and meaning of this experience. At this point, pattern identification involved a cross-comparison from subject to subject in order to determine how the pattern fit overall and in relation to its parts. This process is described by Polkinghorne (1983):

> The tentative pattern is tested by reexamining the examples to see if the pattern holds for all of them--that is, to see if each of the examples can be built up by using the pattern as a 'skeleton' for generating organizational structure. (p. 272)

3. The third step consisted of comparing the interviews as a total group, so that the individual "trees" as well as the "forest" were analyzed for their content. In quoting Glaser (1965, pp. 440-441), Selltiz, Wrightsman and Cook (1976) wrote:

> Thus, the theory develops as different categories and their properties tend to become integrated through constant comparisons which force the analyst to make some related theoretical sense of each comparison. (p. 275)

At this point in the data analysis, the emergent themes led to a return to the literature. Once the men's common psychosocial issues and dilemmas were identified, it was essential to look at how they dealt with those issues within the contexts of stress, coping, and adaptation theory and research.

4. The organizing structures and the "pattern in the patterns" were delineated, abstracted, and compared with existing knowledge in coping theory and clinical practice. The methods chosen for this study led to the formulation of a classification of issues, substantiated by the data, that would generate future research hypotheses concerning the impact of mastectomy on male partners.

CHAPTER IV

ANALYSIS OF INTERVIEW DATA

Introduction

This study explores how nine male subjects met an intense life crisis that involved their personal integration as well as their conjoint relationships. During the 1960s, David Hamburg and his colleagues initiated a series of collaborative studies to investigate how normal individuals cope with life-threatening illness and injury. From their observations of parents of fatally ill children, Chodoff, Friedman, and Hamburg (1963), discovered the following:

> Each parent reacted to the various stresses to which he was exposed in a unique and individual manner. However, viewing the group as a whole, there could be discerned the outlines of a kind of 'natural history' of adaptation to the situation, an almost orderly and predictable sequence of events through which the parents passed. (p. 744)

Within the present study, the data analysis supports the existence of a "natural history" or discernible structure in the men's experience. First, certain externally imposed events were sequential, and the interview schedule was based upon recognition of that sequence. The men talked about these events in three phases: diagnosis, surgery, and recovery. Each phase posed particular problems, which the subjects had to face and deal with. The diagnosis occurred, marking a sharp distinction between life prior to this event and the course of events it initiated; the surgery occurred whether or not the husband was ready for it, as did the recovery phase. Because of this external pressure, and certainly in relation to it, a person either meets or fails to meet the experience. The men in this study were chosen as survivors in two senses, personally and in terms of their conjoint relationships. Although each man and each relationship was unique, both the exigencies of the experience and common social and psychological structures led to a pattern of shared experience.

Description of Subjects

The men were selected based on their wives' situation: women in the age group at highest risk for breast cancer who had undergone breast surgery, and with whom there was a long-term relationship. The study was designed to include men whose relationship seemed to have survived this crisis. Therefore, on the surface, the adjustments seemed to have been successful. The interviews bore out this assumption, judging by previous reports on couples in this stressful situation and the research on coping.

Thus, the men had in common their wives' age range and surgery. They were not selected on the basis of any demographic features of their own, except for length of conjoint relationship.

Table 1 gives the information on age and length of marriage or cohabitation at the time of first and, in three cases, second surgeries. The men's average age at the time of their partners' (first) surgeries was 46.0, and the range of ages was between 32 and 54.5 years. When interviewed, their mean age was 54.3, with a range from 32 to 65 years. The average age of the female partners at the time of (first) surgery was 45.5; their ages ranged from 38 to 52 years. Two women underwent second mastectomies 6.5 and 24 years, respectively, after their first surgeries. A third underwent a cosmetic mastectomy at 1.5 years.

There were no pattern differences between the youngest man of the group (age 32) and the others, who were all middle-aged (over 45) at the time of the interview. (Although one of these men was 32 when his wife had her initial surgery, the majority were over 45). Whether a younger group of men would have perceived and negotiated this experience differently is unknown.

All of the men in the sample were married to their partners. Seven of the nine had been married only once and were still married. Table 1 shows that one man was married four rather than five years. Only one other had been married less than ten years at the time of surgery. On the whole, this was a long-married and rarely divorced set of men. The marriages or cohabitations ranged from 5 to 40 years in length, with a mean of 26.0 years. At the time of

TABLE 1

MEN'S AGES AND YEARS MARRIED OR COHABITING AT FIRST AND SECOND SURGERIES

Subject	Current Age	Age at Surgery:		Years Married or Cohabiting	Years Married or Cohabiting at Surgery	
		First -	Second		First -	Second
1	32	32		5	4	
2	53	51		29.5	27	
3	53.5	50		27	23.5	
4	54	46	52.5	29	21	27.5
5	56	51	47.5	33	28	29.5
6	56	32	56.0	33	9	33.0
7	57	54.5		8	5.5	
8	62	46		35	19	
9	65	51		40	26	
MEAN	54.3	46.0		26.0	18	

surgery, the range was from 4 to 28 years, with a mean of 18.0 years. They had made a long-term commitment to the relationship before the mastectomy and were still in the relationship from 8 months to 28 years after surgery.

Table 2 shows that the amount of time since the first surgery ranged from 8 months to 24 years. The data analysis revealed differences between the 4 men closer to the surgery and the 5 men more distant. (The dividing point was 3.5 years.) There were no perceptible differences between the man whose partner was only 8 months from surgery and the other men in the 3.5 years-and-under category. Three men's wives had had a second surgery 6 weeks, 1.5, and 3.5 years previous to their husbands' interview. One of these surgeries was cosmetic. All three men fit the pattern of subjects distant from the surgery; the second surgeries did not seem to have the impact of a recent first surgery.

TABLE 2

TIME SINCE FIRST SURGERY AT TIME OF STUDY

3.5 Years and Under	More Than 3.5 Years
8 months	5 years*
2 years	8 years*
2.8 years	14 years
3.5 years	16 years
	24 years*
Total number of men: 4	Total number of men: 5

*These men's wives had a second surgery.

There were four main differences between the men distant from the surgery (over 3.5 years) and those closer to it (3.5 years and under):

1. Emotional charge of reaction: The 5 men more distant were less charged, and more philosophical and general in speaking about their feelings.
2. Perception of partners' needs: The 5 men more distant recalled their wives' strength, perhaps the result of a broader view afforded by time. The men closer to the surgery talked about the details of their wives' difficulties and struggles.
3. Perception of length of partner's grieving process: The 5 men more distant saw a shorter grieving process (3 to 6 months), while the men closer to the surgery saw a longer one (over a year).
4. Perceptions of reestablishment of sexual relationship: The men more distant from the surgery gave a more positive assessment of the overall relationship. The men closer to the surgery remembered the problems of adjustment more acutely.

Although recruitment efforts were made to enlist subjects who would reflect a wide range of social, economic, and cultural backgrounds (see Recruitment and Accessibility, chapter III), Table 3 shows that the actual sample consisted of a fairly homogeneous population. All of the subjects were Caucasian. Five of the men were Protestant, 3 Catholic, and 1 nonsectarian. The education level ranged from high school completion to the doctoral level. All but one of the sample had at least one or two years of college or the equivalent in technical training. One subject had a

Ph.D.; one was a part-time doctoral student; four others had completed college. Although not asked about their incomes, all but two men had worked at the same jobs or within their business or professional fields for at least 15 years. These men described a sense of personal pride in their stability and commitment to their work. Although two of the men were over 60 at the time of their interviews, none of the subjects were retired from full-time employment.

Seven of the men's wives were also employed full-time; an eighth worked part-time, and the ninth had been employed full-time before retirement. The majority of the male partners worked in administrative or managerial positions, while the majority of the mastectomees worked in human service fields, primarily nursing and teaching.

All of the men had families of from one to six children. (Two of these men were step fathers.) At the time of the interviews, only one man had a child living at home. At the time of their partners' surgeries, 5 of the subjects had children under 18 years of age in the home.

Phases and Issues of the Men's Experiences

The ways in which the men spoke of their ordeal revealed that, in spite of individual variation, they shared certain categories of experience. They emphasized the same

TABLE 3

SOCIAL AND ECONOMIC INFORMATION

Subject	Religion	Education	Type of Employment
1	Catholic	1 year college	Federal Government employee
2	Protestant	College graduate	Self-employed businessman
3	Protestant	College graduate	Administrator, Federal Government
4	Protestant	College graduate	Administrator, Federal Government
5	Catholic	2 years college	Project manager, private industry
6	Catholic	Ph.D candidate	Administrator, State Government
7	Nonsectarian	College graduate	Self-employed businessman
8	Protestant	Ph.D	Educator - Administrator, State Government
9	Protestant	High School, Technical Training	Manager, private business

issues and had common modes of dealing with them. Having been chosen as examples of men in long-term relationships whose commitments since the surgery had, so far, remained intact, it is not surprising that their common pattern was one of successful adaptation. The main questions the study addressed were: What aspects of the experience did they perceive threatening or difficult, and what resources did they call upon in their successful (at least "normal") adaptation? Furthermore, what did the men stress about their experience?

The data analysis reveals that three sequential phases structured the mastectomy experience: I. Responses to Diagnosis: Initial Confrontation with Partner's Breast Cancer; II. Partner's Hospitalization and Surgery: Impact of Mastectomy; and III. Partner's Recovery Process: Postoperative Reparation. Each phase posed specific problems and raised psychosocial issues the men had to face, appraise, and cope with before the next phase. These issues were:

Phase I: Responses to Diagnosis

A. Preoperative anxiety: fears of loss, death, and abandonment

B. Loss of emotional equilibrium: no preparation, no guidelines

C. Balancing his feelings and her feelings: "being strong" for partner

Phase II: Partner's Hospitalization and Surgery

- A. Postoperative relief: reorganization of feelings and priorities; recovery of emotional equilibrium
- B. Beginning perception of role in partner's recovery: support, reassurance, empathy

Phase III: Partner's Recovery Process

- A. Extension of role in partner's recovery
    - 1. Primary caretaking: tasks, chores, "easing the burden"
    - 2. Reestablishment of emotional and sexual intimacy; impact of partner's altered body image

Phase I: Responses to Diagnosis: Initial Confrontation with Partner's Breast Cancer

Three major issues emerged at this stage. The men struggled with (a) feelings about the possible loss or death of their partners, (b) loss of their emotional equilibrium, and (c) the need to subordinate strong emotional responses in order to be a source of strength and support for their stricken partners. Seven of the nine men expressed with depth and intensity their feelings about the possible death of their loved ones, their anxiety about loss, and their fears of being abandoned; two of the men denied such fears. All nine talked about the degree of emotional imbalance they experienced upon hearing the definitive diagnosis; all nine revealed their efforts to be responsive to their partners' fears of death or disfigurement.

Preoperative Anxiety: Fears of Loss, Death, and Abandonment

Seven of the nine men reported their strongest responses to the diagnosis was a fear of loss or death of their partners. The intensity of their feelings was evident in the men's affectual responses. They talked about how the fear of the possible loss of a loved one made them feel unsure of themselves and the world as they knew it; they felt a loss of emotional balance, and a sense of despair. From her exploration of themes of loss, Simos (1979) wrote:

> Because from early infancy we face the threat of loss in the innumerable experiences of union and separation from the mothering person and later from other valued people, it is understandable that the fear of loss should be deeply buried in all of us. It remains in the unconscious, ever ready to surge up anew as a later loss occurs or as a new threat of loss hovers.
>
> The fear of loss arouses in each of us the infantile, deep-rooted fear of abandonment....Thus, a feeling of anxiety or intense fear accompanies the fear of loss. (pp. 21-22)

This view offers a way of understanding the depth of the men's feelings and their determined efforts to control them both for their own and their partners' welfare. Two subjects did not express fear of their partners' death and denied such feelings. One of these was in the subgroup of five men distant (over 3.5 years) from their partners' first breast surgeries; the other was from the subgroup of four men close to the surgery (3.5 years or less). They described their feelings:

> 1. It never entered my mind that she would die. My first concern was what it would mean to her and being strong for her sake.
>
> 2. I never had any thought in my mind that she would die. I ruled it out. I may not have been facing reality, but if you're in love, the thought of your loved one being taken away is a pretty devastating thing. We dismissed it as a real possibility or alternative.

Although both men verbally denied fears of loss or death of their partners, it was apparent from their overall interview responses that they both had deep feelings of regard for their partners. Denial, as used here, served as one way of coping with the threat of the loss or death of a loved one. Simos (1979) wrote: "Denial operates by shutting out of awareness that which would be too disturbing" (p. 60). As the most primitive and pervasive defense mechanism,... "denial serves to provide a moratorium in time to protect the individual from a flood of emotions and a new reality" (p. 62). Denial has been shown to be a usual first reaction to major loss; it was therefore surprising that more of the subjects did not verbalize their disbelief or rejection of the threat of a major loss. However, other stages of the experience will reveal behavior symptomatic of denial. Denial as a coping mechanism will be discussed in chapter V, Coping and Adaptation.

Three of the men's partners had had two mastectomies. Their first surgeries were respectively 24, 8, and 5 years past; their second surgeries were 6 weeks, and 1.5 and 3.5

years past. The woman whose first surgery occurred five years past had her second breast removed for cosmetic reasons; her partner was also one of the men who denied fears of his partner's death in reference to her first surgery. The other two men reported more acute fears of loss or death at the time their partners had their first surgeries. They talked about their reactions thus:

> 1. It hit me harder the first time, as I was afraid I was going to lose her. I was really down, more so than my wife. Maybe I was selfish, but all I could think about was that I might lose her. I was stronger the second time, since she'd survived the first surgery.
>
> 2. The first time there was a great deal of anxiety on my part. I felt helpless, accepted what I was told, and wondered how I was going to cope with it all. The doctor talked to me, but not extensively. I felt like a bomb was dropped, and I had to pick up all the pieces.

These two men felt their experience in surviving the first surgery helped prepare them for the subsequent surgery. Yet each man also reported that recurrence of the cancer reactivated fears for his partner's survival until the surgery was over and a positive prognosis medically determined.

One man's comments reflected the essence of the other five men's collective responses:

> My first thought was compassion for her. I was afraid I might lose her, she might die. The loss of her breast didn't mean anything to me; I was concerned for her life.

Loss of Emotional Equilibrium

All nine men reported emotional disequilibrium at the time of diagnosis. They described an initial sense of shock or numbness, followed by anticipatory anxiety about what lay ahead and how they were going to face it. The men more distant from the surgery cited less emotionally charged reactions. Their responses ranged from "There is no psychological preparation" and "There are no guidelines" to "It's like having the rug pulled out from under you." The men close to the surgery (under 3.5 years) were more expressive of the emotional impact of the diagnosis:

> 1. It caught me off balance. There was a fear of the unknown. The worst thing was not knowing how bad it was or if I would lose her. I was in a state of shock, and deep down I felt sorry for myself.
>
> 2. I went through the whole gamut of emotions: fear, despair, anger, rage. I was mad about the disease itself, as well as the unnecessary trouble with the ass [physician] who didn't respond to her promptly. I knew I had to come to grips with the unfairness of it all...not only to her, but why does it have to be? I'm not a religious person, although I believe in a supreme being; but you don't run to a minister or priest if you feel like I did. Organized religion has a lot of flaws; so you tend to take it on yourself and try to deal with it the best you can.

The two men who had denied fears of loss or death of their partners both acknowledged feelings of anxiety and apprehension at this stage of the experience. However, both attributed these feelings to their concerns for their partners' welfare rather than their own.

Balancing His and Her Feelings: "Being Strong" for Partner

The need to be strong for their partners was verbalized by all nine subjects, whether for the first or second surgery, whether the fear of loss and death was acknowledged or denied, and whether the man was distant or close to the amputation. The seven men who did not deny their fears of loss felt a need to control their intense reactions to the diagnosis in order to be a source of strength and comfort for their partners. Three men's comments reflect this:

1. I cried a little. The thing was, I couldn't show her any emotions. She didn't want to talk about it, and it ended up being me mostly. I think if I had broken down at that time, it would have hurt her more. One's got to be strong, and it had to be me.
2. My first reaction was that of being mad, then crying. I had to keep my strength so that I wouldn't break down in front of her. I kept myself pretty much under control.
3. I get emotional about certain things. I even cry when I watch television, but I held my emotions back, because I didn't want my wife to think I couldn't cope with it.

The findings demonstrate how deeply affected these men were by the diagnosis of their partners' breast cancer. Fears of the loss or death of their partners and feeling called upon for strength to help mitigate their partners' fears transcended any issue of breast loss itself.

Phase II: Hospitalization and Surgery: Impact of Mastectomy

As the previous section indicated, at the time of the definitive diagnosis of their partners' breast cancer, the men were caught in the dilemma of dealing with their own powerful feelings and at the same time being supportive of their partners. This dilemma was largely resolved once the surgery was over and the men knew their wives were going to survive or had favorable prognoses. The data reveal a consistent pattern reported by the male partners: (a) an immense feeling of relief about the surgical outcome, which led to recovery of emotional equilibrium and a reorganization of feelings and priorities, and (b) a beginning perception of their roles in their partners' recovery processes. Although all nine men saw their roles as major providers of support, reassurance, and empathy, their perceptions of their partners' needs and reactions during this stage differed, depending on distance from the surgery.

Postoperative Relief: Reorganization of Feelings and Priorities; Recovery of Emotional Equilibrium

Two men's comments characterized the subjects' postoperative relief and subsequent affirmation of their supportive roles:

> 1. I was just so relieved that she'd made it and was alive that I could get back to taking care of her and her needs.
>
> 2. I took two weeks off work; once I knew she was going to be OK, once I was relieved of that worry, all I could think about was making things easier for her when she came home.

For the men in this study, the sense of relief and related optimism about the future superseded the acute crisis aspects of the situation. They were able to regain a sense of control, of moving on to meet their partners' immediate needs and the tasks of their partners' recuperation. This sense of relief marked the onset of the men's adjustment process both to their partners' loss and to her altered anatomy.

While the male partners were moving on to assume their roles of major providers of support and reassurance, the female partners were experiencing their own reactions to the surgery. These reactions included feelings about their impaired self-images and the impact of breast loss on self-esteem. As Grandstaff (1975) described: "It is at this time that the woman realizes the full impact of what has happened" (p. 154). Two of the men's responses show the individual ways in which each man attempted to reach the same goal: demonstrating support and dispelling his partner's fear of rejection. Respectively distant from and close to the surgery, they recalled this pivotal period:

1. I was at the hospital as much as possible; so I wasn't away from her too much after the surgery. When we talked about it, she was concerned that it might affect me and needed reassurance that the surgery didn't change anything between us.

2. She felt uncomfortable when she came home with the bandages still on. I never pushed her. I helped with the dressings. I didn't turn my back or say, 'this turns me off.' We didn't try to hide the surgery from ourselves or others. Once it was done, I just accepted it.

Beginning Perception of Role in Partner's Recovery

Avery (1984), in a newspaper article "Mastectomy," addressed the male partner's role confusion during the postoperative stages and quoted Wellisch (1978):

> Most men simply don't know what to do for their wives. They ask, 'How can I help my partner feel OK about herself? What should I say? What should I do?' (p. 4)

Referring to the traditional cultural role expectations of American men, he further commented:

> In our society men are expected to be doers, to make problems go away. Here's a situation where no matter how clever or articulate they are, they can't make their partners' feelings disappear. That's a very hard thing for men to deal with. (p. 4)

He advised men:

> I tell them not to expect to make their wives feel better. The best they can do is shut up and listen. If they can do that, they're doing great. (p. 4)

The men in this study were more resourceful in defining their roles than Wellisch found. Once the surgery was over and their worst fears abated, the men quickly overcame temporary concerns about what to say or do; their efforts were focused upon their partners' physical and emotional recoveries. Collectively, they saw themselves as the major providers of support, reassurance, and empathy. However, each man's role in caring for his partner was affected by his perception of how she was dealing with the situation and of her needs.

The five men most distant from their partners' first surgeries reported a different perception; they remembered the strength and determination with which their partners dealt with the situation. These men felt that their wives' positive attitudes made it easier to maintain open communication and joint decision making, and to ensure the continuity of the relationship. Tempered by time, these men talked with philosophical ease from a wider perspective. Three men's responses reflect this subgroup's recollections of the hospital and surgery phase:

> 1. I tried to be compassionate. I knew she would be there for me if something happened to me. You have to be supportive and let her know how much you love her and want the relationship to continue. I was told my many of her friends that I was so supportive, but I don't really know what I did. I could only be there to listen and reassure. She's the one who had to make the real adjustments. I was just me, just being myself, just being normal.
>
> 2. Women like my wife make it easier to get through. Because she was so strong willed and positive, she often carried me. She was determined to lick it. People have commented about the marvelous way I reacted, but she deserves the credit.
>
> 3. She saw it [the surgery] as some kind of message that she'd better change her lifestyle. She began to change her way of thinking, as she saw it as a second chance at life. Later she began to assert herself more in the world and in her relationships, and I supported her independence.

The four men closest to the surgery (under 3.5 years) recalled the details of their partners' struggles during this phase. They remembered their partners' emotional pain and their efforts to listen and offer verbal reassurance as their wives went through the grieving process and mourned for the lost breast. One man vividly described the sequence of his partner's grieving process:

> Hers wasn't depression at first, that came later. After she was home and up and around, she seemed hostile, cranky, probably agitated about her loss for about two or three months.

The three other men closest to the surgery remembered their partners' frequent needs for reassurance both about their physical attractiveness and their husbands' continued affection. Their attempts to respond to those needs helped prepare them for their ongoing supportive roles in the recovery process. They talked about the postsurgery phase in the following ways:

1. I'd try to be patient and listen. It was hard, as I thought I should be doing more. She needed a lot of reassurance. I had to let her know that she was still the same woman I married and two breasts a woman does not make. Sometimes she still doesn't feel like she's a woman, and I keep reassuring her that I still love her.

2. After the hospital, she was moody, wouldn't talk about it, was in more of a denial stage. Even now, she doesn't like me to look at it....I supported her more verbally because she got so low, reassuring her she would be OK; she still needs reassuring.

3. She's still adjusting. She has an intermittent need for reassurance rather than a constant need. But she'll make it; she's one strong lady.

The men distant from the surgery viewed their partners' grieving process as lasting from three to six months. The men close to the surgery saw it as extending a year or longer.

Phase III: Partner's Recovery Process: Postoperative Reparation

The recovery phase brought up new issues for the men, requiring an extension of their supportive roles. Two major issues emerged: (a) primary caretaking and (b) reestablishment of the intimate and sexual relationship. Primary caretaking included those active tasks the men took on both to keep themselves busy and to ease their partners' burdens in the home and family. Reestablishment of the intimate and sexual relationship included each man's concerns and efforts to support his partner toward a physical and emotional readiness to resume sexual intimacy. As this mutual adjustment process was facilitated by the male partner's emotional support, it will be discussed here rather than in the chapter Coping and Adaptation. Although seven men reported initial aversion to the wound and scar site, the findings show that all nine were able to accept their partners' altered body images and resume sexual intimacy.

Primary Caretaking

The men gave a range of responses about the more obvious manifestations of support. This range included such activities as helping out at home with the household chores (although all but two of the men had been comfortable in sharing these tasks before surgery); hiring outside help for household or family care (one man had six children under seven years of age when his partner had the first of two surgeries); inviting their partners' mothers, sisters, and best friends for extended visits; offering gifts, flowers, restaurant dining, and dancing (once the wound site was sufficiently healed); running errands; transporting their partners to medical appointments and chemotherapy and radiation therapy treatments; helping their partners select prostheses; ministering to the concerns of children, family, and friends; and in three situations, supporting their partners in their decision-making choices about breast reconstruction surgery.

However, when asked about what they individually did to show their support, the men gave more subtle and personal accounts of their caring and reassuring behavior during the recuperative phase than in the earlier ones. One subject whose partner had both breasts removed talked about his initial feelings of overprotectiveness:

> Even in the hospital, I was being overly protective. I screened who could come and see her and who couldn't. Once she came home, I wanted to shield her, but that was the wrong thing to do. You can't shield anyone. They have to face it themselves. There's just too much exposure to cancer in the world through newspapers and television. You can only be there for them as they adjust.

From "being strong" for their partners at the time of diagnosis and surgery, the men's position shifted to that of "being there for them while they adjust." The men distant from the surgery again were more global in their recollections. As two men recalled:

> 1. We never made the mastectomy a taboo subject; it was out in the open, right out front, from the start; we told our friends and our church group. We had to be honest with ourselves in order to be honest with others. We've always faced things together.
>
> 2. She was the one who had to do the real adjusting. I could only be there and be available to listen and hold her hand.

The men close to the surgery more acutely remembered their efforts to ease the burden. As one man shared:

> I had her sister come. Even though I don't really like this sister, she's close to my wife and could help and comfort her while I was at work.

Reestablishment of Emotional and Sexual Intimacy

All of the men either viewed the wound in the hospital or soon after their partners returned home. All but two described feelings of initial aversion as they confronted the reality of the amputation. The men distant from the surgery recalled the initial viewing as vividly as the men close to it. However, the men distant countered negative reactions with overall positive assessments of the intimate and sexual relationship. The men close to the surgery remembered more of the problems they encountered in resuming sexual closeness. The men distant from the surgery talked about it in the following ways:

> 1. Well, that was a shock. At first, it's awful. After a few weeks, I accepted it. It's not such a big deal. The surgery didn't present a sexual problem. In fact, our lovemaking has become more tender and meaningful. We savor what we have together; there's a more poignant quality.

> 2. You can't help but have some reaction [to the scar], but there are other ways to show your love. You learn to compensate in other ways. Just because a woman has a mastectomy-so what? She can still be a great sexual partner....I can't understand why some men would leave or get a divorce; she's still the same woman you married. Some men are immature. You don't marry her just for sex.
>
> 3. She was taking a bath, and she said, 'I had trouble looking at myself, but I think you should, too. How bad do I look?' I told her, 'You look like a lady who's lost a breast.' It takes some getting used to, but it's just part of the body. We're both the type to talk things over together. I was willing to adjust because we've been married over thirty years; we're in love.
>
> 4. At first I felt repulsion; it's not a pretty sight....I approached the situation on several levels. I'm strongly attracted to physical beauty and repulsed by physical impairment. But on another level is the realization that one or two breasts does not make a woman. There are other kinds of attractiveness that are more important. Although it's certainly nice to have the whole package, it's certainly not essential to a good relationship. That's the level that dictates my reactions as opposed to the first level.
>
> 5. It's [the wound] part of her anatomy. It has an effect, but you have to make an adjustment that doesn't translate into rejection, which would be a real concern for her. It has to be a tremendous adjustment for the woman.

Witkin (1975) advocated a candid exchange of reactive feelings as essential to reestablishing intimacy:

> In brief, each fears a negative response by the other. The solution, for both, is to express and share their fears and their emotions. Neither has to put up a brave front; neither has to pretend to be unaffected by the operation. If the husband makes clear that any 'shaken-up' response does not apply to his wife but to her loss, and his reaction is due to empathy rather than antipathy, the couple has little to worry about. (p. 294)

The men close to the surgery remembered sharing their partners' fears and emotions; each talked about his efforts to respond to her loss with empathy for what she was going through.

> 1. She asked me if I wanted to see her scar after she'd been home a few days. We were in the bedroom. I think I tried to make a little joke to ease the situation. We're both used to laughing and making jokes together. Maybe it was a way of hiding our deep and sincere feelings about it then, but I don't think so; it just didn't make that big a difference in the way we cared for each other. She was worried about our intimate life, how I would respond to her body. We communicate and talk about it whenever it's needed. I needed to let her know that my compassion, my feelings, pain came from what she was going through and not from a missing body part.
>
> 2. She was worried that I would have a 'mammary problem.' But I saw her more as a person wounded or having suffered; I didn't feel turned off. It didn't concern me about the [breast] loss; my major concern was that she lived, and it is still my major concern. I know there's a societal emphasis on the breast, the same as with men as 'hunks' or 'beefcake'....But I've always reassured her that there's still another one [for making love].
>
> 3. I have more of a knowledge about this than most men [military medical experience], and it gave me an idea of what to expect--like not pushing the intimate life and wait until she was ready....It was about six weeks after she came home from the hospital. She's still inhibited. She wears a bra or keeps a top on. I think this [inhibition] will go away in time. It hasn't made an impact because it doesn't bother me. The frequency is the same; it's just that she's inhibited and needs to keep her top on right now.

Only one of the subjects described the surgery as negatively affecting the sexual relationship once it was resumed. He reported that he had seen the wound in the hospital:

> 4. They came in to dress it and she asked if I wanted to see it, and I said 'sure'. I was trying to treat it without emotion. However, they didn't prepare me that our sex life would change [due to postsurgery medical treatments]. It wasn't psychological, it was physical. We talked about it and dealt with it. People who want to help should inform you about possible sexual problems.

Although two subjects most recent to the surgery described adjustment issues related to the partner's inhibition or physical discomfort resulting from chemotherapy treatments, the data also reveal that four men viewed their sexual relationships with their partners as improved since the surgery. One (quoted above) described a more tender, poignant, and meaningful relationship; another described his wife as "a great sexual partner". Two other men (one distant and one close to surgery) referred to an enhancement of their sexual partnership. The man distant volunteered:

> I think our lovemaking has become more adventuresome. When you lose one erotic area, you have the excitement of discovering other ones together.

The man close to surgery concurred: "She's still the same woman I married, and there are other ways you can get aroused together." The remaining three men concluded that the mastectomy hadn't made any significant differences in their intimate and sexual relationships.

Although the men acknowledged individual reactions to the amputations that ranged from "repulsion" to "it takes some getting used to," the data reveal that the male partners were able to accept their wives' altered body images. The data further reveal that the process of acceptance included three major steps. The first was the male partner's initial viewing of the scar. Although all but two of the men described initial aversion reactions, viewing the amputation replaced imagined or fantasized images with reality. As one subject concluded, "After a few weeks, it was no big deal." The second step was an open, candid exchange of feelings and emotional responses with the partner. The third step was the reassurance the male partners experienced with the resumption of the couple's sexual intimacy. In turn, this reassurance enabled the subjects to reinforce their partners' self-esteem and feminine self-image. The resumption of lovemaking also served to diminish the female partners' fears about sexual desireableness and rejection by their partners.

CHAPTER V

COPING AND ADAPTATION

Introduction

For the men in this study, confronting their partners' breast cancers became an exacting test of their coping abilities. Chapter IV addressed the psychosocial issues each man had to face; this chapter addresses the coping resources he mobilized to deal with those issues and the adaptational outcome.

The major patterns that emerged from the data showed the natural history of a stressful experience, the phases of that experience, the types of stress and psychosocial issues brought up by each phase, and the resources these men used in their adaptational efforts. Although the literature and research on mastectomy and its psychosocial effects was useful in formulating the research questions and interview guide, they were not sufficient to provide a theoretical framework for understanding the findings. The literature on grief and mourning was expected to provide such a structure. However, the data analysis showed that coping with and adapting to a major life crisis were the predominant issues. The literature on stress, coping, and adaptation therefore provided a more relevant theoretical context.

Originally, the study's intent was to identify the men's psychosocial issues and the resources they used or desired. It was assumed and established that the male partner of the mastectomee was intensely involved in a stressful experience. Another assumption was that the symbolic nature of the breast (social and psychological), as well as its sexual significance, would impose a particular stress. The data presented in the previous chapter showed that although these issues specifically affected the recovery phase (reestablishment of sexual intimacy), the overriding issues were common to other highly stressful experiences, particularly the possible death of a loved one or family member. These overriding issues were: coping with the stress of the feared loss while supplying the support needed by the suffering loved one and successfully negotiating the various phases of the experience. The men also faced specific issues relating to their cultural identity as "provider" and "the strong one." These issues surface in other research revealing a sexual difference in the use of certain coping methods (see discussion in chapter VI). However, the question of how normal people cope with this kind of stress and what characterizes this particular coping are the common threads linking the present research to other work.

This chapter will first discuss relevant literature on how normal people cope with the life-threatening illness of a family member or loved one. A later discussion of the men's coping and adjustment processes will refer to this research. Then, the theoretical works that address coping and adaptation will be examined, focusing on the theoretical framework of Richard Lazarus and his colleagues. The last two sections of this chapter will present the study findings on the men's effective coping strategies and successful adaptational outcomes.

Research Literature: Coping with a Loved One's Severe Illness

Several studies focused upon individual coping behavior related to illness or injury: severe burns (Hamburg, Hamburg, & deGoza, 1953; Hamburg, Artz, Reiss, Amspacher & Chambers, 1953); surgical patients (Janis, 1958; Cohen & Lazarus, 1973), severe poliomyelitis (Visotsky, Hamburg, Goss, & Lebovits, 1961); and intrinsic asthma (de Araujo, Van Arsdel, Holmes, & Dudley, 1973). Three published studies that focused upon the coping efforts of the spouse and family are particularly relevant to the present study. Of the three, two presented clinical observations on the same group of parents of fatally ill children. Chodoff, Friedman, and Hamburg (1963) described the stress, defenses, and coping behavior of the parents. Hamburg and Adams (1967) reviewed their collaborative studies of coping (including the above mentioned study) from a single perspective: the seeking and utilization of information under stressful conditions. A third study by Skelton and Dominian (1973) described the emotional effects of the male's heart attack on his female partner. Comparisons of these study findings with those of the present study will be made in chapter VI.

Chodoff et al. (1963) reported clinical observations on the coping and adaptational behavior of 46 parents of 27 children with leukemia or other malignant diseases who were referred for treatment with chemotherapeutic agents at a national cancer center. The authors made their observations during a two-year investigation of the parents' adrenal cortex responses under conditons of chronic psychological stress. Thirty-five of the parents (20 mothers and 15 fathers), who resided some distance from the center, spent a median period of one month (fathers) and two months (mothers) in a ward at the clinical center; the other 11 parents (6 mothers and 5 fathers), who lived in the immediate vicinity, participated on an outpatient basis. The median age of the 26 mothers was 33 years; that of the 20 fathers was 35 years. The majority were high-school graduates; they represented middle and lower-middle income and social ranges; they were predominantly Caucasian and Protestant, and had both urban and rural backgrounds.

Each parent had the difficult role of caring for a slowly dying child over a duration of one week to eight months. The authors described what they considered the parents' normal, rather than pathological, defenses during the ordeal; isolation of affect, denial, and motor activity. They discussed the parents' need to "search for meaning" in their tragic circumstances. They found that the parents were able to function effectively through their children's hospitalization without being overwhelmed by depression and anxiety; the parents maintained personal integration, important relationships, and some degree of self-esteem.

Men have more heart attacks than women. Therefore, it was not surprising to find five published studies since 1967 that described the psychosocial problems of wives of men who had suffered a myocardial infarction. Skelton and Dominian's (1973) study delineated phases of the wives' experience that both corresponded to and contrasted with those of the men in the present study.

Skelton and Dominian (1973) explored the psychological effects of myocardial infarctions on 65 wives of 74 husbands admitted to a coronary care unit. The men were all under 64 years of age; the mean age of the wives was 52 (the range was from 36 to 67). The study described the feelings, reactions, and difficulties the wives experienced from the time of the husband's admission to a year after the illness. Their anxieties and dilemmas were described in three phases: the initial illness, the early convalescence period, and one year after the onset of the illness.

They reported that 38% of the wives found the convalescence period after hospital discharge extremely stressful. The authors attributed this to fears of recurrence, death, or permanent incapacity, as well as marital tension. The tension resulted from their husbands' increased dependency and irritability and the wives' depression and guilt. If they were attentive, the wives were accused of being "over-protective and smothering"; if they showed less concern, they were viewed by their husbands "unsympathetic" (p. 102). This bind is similar to the one Witkin (1979) described as the mastectomy "bind" experienced by male partners during the early recovery period following the female's breast surgery. At the end of a year, Skelton and Dominian (1973) found that the fears and anxieties had decreased; only eight of the wives showed poor adjustment when the husband had made a positive physical recovery. The authors emphasized the vital impact the wife's emotional attitude and ability to cope had on the husband's rehabilitation process.

A common concern in the above-mentioned studies is normal adjustment; Hamburg and Adams (1967) addressed some of the conceptual issues. Within their studies of coping with incapacitating and life-threatening illnesses, they observed how well the patients came through extremely difficult personal crises. They were among the behavioral scientists in the 1960s who were seriously concerned with coping, problem-solving, and adaptive behavior. They regarded processes such as repression, denial, reaction formation, and rationalization as "centrally concerned with minimizing recognition of potentially distressing aspects of human experience" (p. 277). They defined "defense mechanisms" as reliance upon avoidance and reduction of painful elements at all costs, leading to self-deception. They questioned whether defensive processes represented but one class of responses to threatening elements of experience, and were interested in finding other significant ways in which normal people coped with stressful experiences. They observed that many people made successful psychosocial recoveries without disintegrating or being psychologically overwhelmed. Their subjects showed resiliency and the ability to work out new patterns of living; they coped with stressful experiences in many ways, not only through the ego defense mechanisms. Most significantly, the author's found that people often grew from stressful life events. The findings of the present study corroborated these observations.

Theoretical Framework: Stress, Coping and Adaptation

Richard Lazarus shared Hamburg and Adams' (1967) search for means other then "defense mechanisms" to understand coping with stress. Maintaining that too much attention had been focused upon the defensive processes, Lazarus and Launier (1978) argued that preoccupation with them overemphasized failure of coping and pathology rather than effectiveness and growth (p. 311). In developing the cognitive-phenomenological theory of psychological stress, Lazarus and his colleagues took a transactional approach to man and his environment. Their conceptualization of stress appraisal, coping, and adaptational outcome is relevant to the present study.

The terms "stress" and "coping" are widely used in psychological literature and clinical practice; they are also commonly used in everyday conversation and have become incorporated into our colloquial vocabulary. The concept of stress derived from engineering theory; it achieved prominence during both the Second World War and the Korean War. Concern about the problems of men undergoing combat resulted in Grinker and Spiegel's (1945) classic study of air force men and the conditions under which they adapted or maladapted to their extremely stressful battle situations. Few systematic works containing other than anecdotal clincical observations were published on coping before the 1960s; they emerged as research interest shifted from stress per se to the ways people respond to stress. Lazarus and Folkman (1984) observed, "Since the 1960s there has been growing recognition that while stress is an inevitable aspect of the human condition, it is coping that makes the big difference in adaptational outcome" (p. 6).

The concept of coping evolved from such diverse sources as animal experimentation and psychoanalytical theory. The animal model was viewed as having little relevance to understanding coping and defense in human behavior; the psychoanalytical model focused upon the defensive function of the ego in dealing with stress. According to Vaillant (1971), this function "describes a habitual, unconscious, and sometimes pathological mental process that is employed to resolve conflict between instinctual needs, internalized prohibitions, and external reality" (p. 107).

In his efforts to add to theory of adult development, Vaillant (1977), as part of an ongoing longitudinal study of a sample of Harvard men, identified adaptive and maladaptive defense mechanisms related to psychological well-being and overall adjustment to life. He developed a formal theoretical scheme of 18 defense mechanisms, which he believed were part of a dynamic, restorative process rather than an abnormal one; they were normal responses to abnormal circumstances (p. 9).

Lazarus and Folkman (1984) disagreed with Vaillant's conception of coping as the adaptive application of defense mechanisms. They argued that hierarchial systems for classifying ego processes such as Vaillant's (1977) had four major limitations: (a) the emphasis on coping as a structural trait or style rather than on the coping processes themselves; (b) the failure to distinguish coping from automatic adaptive behavior; (c) the equation of coping with outcome, and (d) confusion between coping and mastery over the environment (p. 128).

Lazarus and Folkman (1984) addressed these limitations in their definition of coping. First, a look at Lazarus' theory of psychological stress will help place the definition in context. Stress is a transaction in which automatic coping responses are not sufficient to meet the demands of the situation and in which further coping resources must be activated. Stress is defined as:

> any event in which environmental or internal demands (or both) tax and exceed the adaptive resources of the individual, social system, or tissue system. (Lazarus & Launier, 1978, p. 296)

The authors see person and environment in a continuing reciprocal relationship; people make cognitive and behavioral efforts to tolerate, minimize, accept, avoid, or master the source of stress. Two psychological processes mediate the relationship between the person and his environment: appraisal and coping.

"Appraisal" is the cognitive process through which a person evaluates a stressful situation according to what the risk is to one's well-being (primary appraisal) and what coping alternatives are available (secondary appraisal). Reappraisals involve feedback from the environment and from one's own reactions at a later time. Folkman and Lazarus (1980) described three major types of stressful appraisals: harm-loss, threat, and challenge. They explained:

> The degree to which a person experiences psychological stress, that is, feels harmed, threatened, or challenged, is determined by the relationship between the person and the environment in that specific encounter as it is defined both by the evaluation of what is at stake and the evaluation of coping resources and options. (p. 223)

In this study, the stressful event is the female partners' breast cancer and mastectomy. The men made primary and secondary appraisals continuously throughout the diagnostic, hospitalization, and recovery phases. Reappraisals continued, with the interview process itself becoming an opportunity for them, as was evident when the men spoke of "how they made it through."

Lazarus and Folkman (1984) defined "coping" as:

> constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person. (p. 141)

Within Lazarus and his colleagues' theory, coping with stress includes a broad range of complex thoughts and actions, both behavioral and intrapsychic. Lazarus and Launier (1979) indicated that coping involves sequences (or stages) of these thoughts and acts over time and across a wide range of short-term and long-term adaptations (p. 309).

As the study findings showed, Lazarus and his colleagues' concepts helped in understanding the men's attempts to appraise and cope with the internal and external demands of their situations. The following discussion of the men's coping and adaptation draws upon Lazarus' theory, as well as empirical findings of previously discussed research.

The Men's Coping Processes

Description of the Dilemma

As established in the previous sections of this study, the men faced certain common issues within the three phases of the mastectomy experience. They also faced a common dilemma in their attempts to resolve the issues: how to cope with their own intense feelings while being responsive to those of their stricken partners. In the diagnostic phase, the men struggled with fears of possible death and abandonment. At the same time, they felt they needed to subordinate those fears for their partners' sakes. During the hospitalization and surgery phase, their basic fears abated, once they knew their partners would survive; they then saw themselves as the major sources of strength and support during their wives' physical and emotional recoveries. However, they faced the same dilemma when they had to cope with both their own and their partners' feelings about the intimate and sexual ramifications of the breast loss itself during the recovery phase. Throughout the overall experience, the men struggled with the intensity of their varying feelings while caring for their partners. This section will discuss Lazarus and his collegues' indicators of coping effectiveness, and then the sequence of coping strategies the men used to come to terms with a significant threat to their psychological stability.

Effective Coping Indicators

According to Lazarus and Folkman (1984), coping strategies are inherently neither good nor bad: "The effectiveness of a coping strategy depends on the extent to which it is appropriate to the internal and/or external demands of the situation" (p. 185). For coping to be effective in a stressful encounter, two functions must take place: The distress has to be relieved (emotion-focused coping), and the problem causing the distress has to be managed (problem-focused coping). From his study of Nazi concentration camp survivors, Dimsdale (1974), a colleague of Lazarus', observed, "Truly functional coping behavior not only lessens the immediate impact of stress but also allows the person to maintain some sense of self-worth and unity with his past and anticipated future" (p. 792). The three indicators of coping effectiveness covered here are: managing the stressful situation, reducing feelings of personal distress, and maintaining a sense of personal worth and continuity.

The various criteria of effective coping behavior that have emerged from the research of Visotsky et al. (1961), Hamburg and Adams (1967), Caplan (1974), and Mechanic (1974) are all congruent with the theoretical framework set forward by Lazarus and his colleagues. Hamburg and Adams gave this list of criteria for effective coping: (a) keeping distress within manageable limits, (b) maintaining a sense of personal worth, (c) restoring relations with significant other people, and (d) meeting the requirements of the stressful tasks (p. 283).

The findings of this study showed that the men used coping strategies that were appropriate to the internal and external requirements of their situations and congruent with these indicators of coping effectiveness. Furthermore, all of the men maintained their personal relationships, an aspect of coping that Visotsky et al. (1961), Hamburg and Adams (1967), and Caplan (1974) stressed.

The Men's Coping Strategies

The data analysis revealed that the men used a common set of coping strategies in their attempts to deal with their emotions and the outside world. They were: (a) acquisition of information, (b) reestablishment of a sense of control of one's emotions, (c) constructive motor activity, (d) use of available personal support sources, (e) denial, (f) maintenance of open communication with the partner, and (g) a point of view about "how we made it through." This last strategy supports Dimsdale's (1974) observation that effective coping includes maintenance of a sense of self-worth and continuity of life experiences (p. 792). The point of view reflected the men's perceptions of the inner resources (attitudes, values, and beliefs) and previous life experiences that enabled them to cope with the stress and mediate the internal and external demands of their situations.

Each of these coping strategies addressed at least one, and often all three, of the coping indicators discussed. For example, when the men sought information about their partners' illness, they were both managing the problem and alleviating internal distress. By keeping busy with caretaking tasks, they gave themselves an active problem-solving role, which also reduced anxiety and maintained a feeling of self-worth. As evident from the data, the men's coping styles both reduced the personal distress and met the requirements of the stressful tasks while affirming a sense of personal worth.

Acquisition of Information

Within his framework of coping and adjustment theory, Lazarus (1961) described the individual's need to institute a search before taking action: "If the danger is external, the person can often take active steps to eliminate or reduce it by addressing himself directly to the threatening circumstances" (p. 211). He referred to this search as"...direct preparatory action which is designed to strengthen the person's resources against the harm..." (p. 211). He viewed the search itself as a form of direct action which "...is instituted by the person to learn what he must face and to select the most adequate alternative, especially if the danger is preceded by sufficient warning" (p. 211).

When confronted with the diagnosis of their partners' breast cancer, all of the men reported a common need to solicit medical information relevant to the disease itself, the surgical procedures, and their partners' prognoses. The men acquired this information through interactions with a variety of medical specialists (internists, gynecologists, general practitioners, surgeons, oncologists). The search for and acquisition of medical information represented the first step in the men's coping processes.

Responses ranging from, "If the doctor hadn't answered all our questions, we would have found another doctor" to, "It wasn't a matter of the doctor 'offering' to include me [presurgery conference] as much as my insisting I be included [if he had not] that was first in my mind," revealed the men's determined efforts to (a) acquire information that would enable them to strengthen their resources against the harm and (b) manifest their support of their partners.

Reestablishment of a Sense of Control of One's Emotions

By appraising what they must face and by attempting to encapsulate their most distressing fears into manageable elements, the acquisition of information also served another important coping function: It provided the subjects with a frame of reference for reestablishing a sense of control over their internal anxiety during the diagnostic phase. One man's comments summarized the men's responses: "Knowing the concrete facts helped me to separate fact from fiction and know what we were really up against."

During the hospitalization and surgery phase, the men's sense of control was reinforced by their relief when assured of their partners' survival and favorable prognoses. They could then focus upon their wives' needs, rather than their own, as they moved to a supportive and caretaking role.

Constructive Motor Activity

In the process of focusing upon their partners' needs after the surgery, the men performed a myriad of tasks within the home and family in order to "ease her burdens." At the same time, the act of keeping usefully busy (a) served as a means of coping with anxiety and (b) moved them from anxiety-induced passivity to constructive activity. It was important for the men to have a sense of being able to "do something" by taking the initiative in some physical or interpersonal action. As one of the men commented, "I was always ready to listen and reassure, but it helped me a lot to have something specific I could do for her, like cooking dinner, where I could actually see that I was helping her." Chodoff et al. (1963) also found motor activity an important adaptive device in their study of parents of fatally ill children (Comparisons of findings will be discussed in chapter VI).

Use of Available Personal Support Sources

Although uniform in their attempts to reach out for concrete medical information in the diagnostic phase, the men differed sharply about reaching out to others for personal support and reassurance to aid them in coping with their feelings during the hospitalization and surgery phase. Four of the men, including the two who had denied fears of their partners' possible deaths, emphatically denied the need for any nurturant support sources other than family members and/or close friends. These men, both distant and close to the surgery, reflected traditional social attitudes about male autonomy and reluctance to depend upon others. Taking pride in their stoicism and self-reliance, they talked about it in the following ways:

1. The doctors took care of my questions. I personally didn't need anyone outside people in my family. I'm a strong enough person that I can cope with these kinds of things. I guess someone who's not as strong would need outside help or counseling. It may be more traumatic for younger men or newly married ones. I don't think anyone should try to counsel people if they haven't been there themselves. I don't think a 22-year-old talking to a 55-year-old man knows what's going on with him.

2. I had my daughter and a close group of friends. It would be helpful to have other men to talk with [who have been through the experience], but I doubt that I would have taken advantage of it. I don't think men feel comfortable going outside the family.

3. I don't recall sitting down and talking to anybody about, 'Woe is me, my wife is in the hospital with breast cancer.' I spent so much time at the hospital, for one thing. I don't believe in

> wallowing in my misery. I don't mean to sound strong-macho, able to hold up without any help. I just really didn't feel the need to turn to anyone beside my wife and kids. I just felt so concerned with being there for her, letting her know I cared.

> 4. Both my wife and I are strong-willed and independent. I just needed my kids; I didn't really need anyone other than my family.

The other five men saw the use of external support for coping purposes quite differently. They were more self-reflective and articulate about their own changing attitudes within the broader framework of changing expectations of men. They talked more easily about their ambivalence in seeking and receiving external personal support, the support networks they used beyond immediate family and close friends (extended family, clergymen, people at work, neighbors, community resources), as well as support systems that would have further aided them in coping with their traumatic situations. They spoke in the following ways:

> 1. No one outside the family ever talked with me [hospital staff] while she was in the hospital...I think a men's group could offer support. It's helpful to rally around. Men don't talk together about these kinds of things. Men are competitive, younger men especially. Men basically go out to lunch and need an agenda. Women go out to lunch just for the hell of it...Men are supposed to be strong and stoic. Counselors have a special understanding; friends don't always know what to say or do.
>
> 2. I owe a debt of gratitude to some of the social agencies for homemaker services and a succession of babysitters. They helped me to cope with being a mother as well as a father and running a household. I didn't need them to have someone to

> talk to for myself. The first time around I wouldn't have felt comfortable, but after this [second] surgery, I'll talk to anyone willing to listen. I don't have the compulsion to keep it all to myself. Twenty years ago you sure as hell wouldn't share your feelings.

> 3. Men have trouble reaching outside the family, but lots of things are changing. It would be a good thing if there was some kind of service for men that they could turn to. Since there are no guidelines, you just do the best you can. Of course,, I had a lot of support from others [relatives, close friends, minister, people at work].

In the same vein, two men close to the surgery described their mixed feelings about seeking and receiving external support; they both also appealed for more preparation or help for other men facing the experience:

> 4. I don't take to a lot of counseling. When I want information, I go out and look for it. Women get their wagons around the campfire pretty quickly, as they're all susceptible. Men don't seek help as easily as women do; women are a hell of a lot smarter about this kind of thing. It's the macho image society has handed men; we're supposed to be strong and self-sufficient. But something is needed. Men just aren't prepared enough for the psychological aspects. I didn't know all that was going to happen, what an assault it was on her femininity. Nobody ever said that.

> 5. Everybody was concerned about her. Both my family and hers were supportive of me, but they were more concerned about her, which is logical. All illnesses are concentrated on the person who's sick, and what I learned is that they don't really think about what the other person (spouse) is really going through. It would help to know what another man's gone through, what types of mood changes, sexual changes to expect. A group for men who have gone through it would be helpful. I may have attended only once or twice, but it's good to not go in blind and have to feel your way along.

It should be noted that only the fourth man above (one man of the five who showed changing attitudes towards use of external emotional support) actually used such support. Thus, only one out of the nine subjects availed himself of it. However, all of the men in this study maintained and received support from their relatives or close family members and friends.

Denial

According to Lazarus and Folkman's (1984) definition, coping has two aspects: an externally directed one and an internally directed (defensive) one. The defensive aspect protects the individual from overwhelming anxiety so that the individual can focus upon the external problems. However, as Chodoff et al. (1963) pointed out, "Since all defense has a denying function, it is difficult to avoid impreciseness in discussing denial as a specific defense" (p.745). Within the context of this study, the term denial is used to describe "the kind of behavior which indicates a failure to accept the truth or reality of a fact or its consequences" (p. 744). Lazarus and Folkman (1984) succinctly refer to denial as "a disavowal of reality" (p. 136). Although varying in degree of intensity and its manifestation, denial was primarily evident within the first two phases of the men's experience. In the diagnostic phase, two men denied fears of loss, death, and abandonment. In the hospitalization and surgery phase, four men, including the two above, denied the need for external personal support sources in coping with their feelings. Although the recovery phase contained issues involving the sexual and intimate ramifications of the breast loss itself, denial processes were not as much in evidence. By then, these men had to come to a gradual acceptance of their situations.

Lazarus and Folkman (1984) described both the costs and the benefits of denial and denial-like processes:

> 1. When there is nothing constructive that people can do to overcome a harm or threat, that is, when there is no direct action that is relevant, denial and denial-like processes contain the potential for alleviating distress without altering functioning or producing additional harm.
>
> 2. Denial and denial-like processes may be adaptive with respect to certain facets of the situation, but not the whole.
>
> 3. The timing of denial and denial-like forms of coping may be a major significance. Denial may be less damaging and more effective in the early stages of a crisis, such as sudden illness, incapacitation, or loss of a loved one, when the situation cannot yet be faced in its entirety, than in later stages. (p. 137)

In the diagnostic phase, denial probably served a useful function for the two men by helping them to avoid being overwhelmed by anxiety and permitting them to make a more gradual transition to adaptive activities. As Chodoff et al. (1963) observed, "By damping down the perception or impact of disturbing events, the defenses served the purpose of clearing the decks for whatever sort of coping action was most appropriate to the style of the particular parent"

(p. 746). The use of denial represented efforts to sustain morale and constructive efforts to cope rather than a rejection of reality.

One of the preferred ways of coping is maintenance of relations with significant others. As mentioned above, all of the men, including the four who denied the need for external support during the hospitalization and surgery phase, did in fact maintain their relations with significant family and close friends. In effect, these men were denying their dependency needs. Their resistance to using coping sources that helped others deal with stress reflected their identification with traditional male attitudes and values. In their study of parents of terminally ill children, Chodoff et al. (1963) found that it was harder for the male parents to use some of the coping strategies than for the female parents:

> Secondary stresses of adjustment to a new and entirely strange environment were often handled better by the mothers who fitted more easily into preformed nursing and mothering roles than by the fathers, who, removed from their usual occupations, seemed harder hit and less adroit at dealing with the unaccustomed social environment of the parents' ward. (p. 744)

Other examples of denial-like behavior during the three phases of the men's experience include: (a) projection of anger and resentment upon physicians and medical care (diagnostic phase); (b) somatic reactions, including temporary changes in sleeping and eating patterns and occasional use of alcohol (hospitalization and surgery phase); and (c) over-absorption with caretaking roles and tasks (recovery phase). However, these were not predominant themes and did not form a consistent pattern. Rather, they seem to emphasize Lazarus and Folkman's (1984) point that "denial-like processes may be adaptive with respect to certain facets of the situation, but not the whole" (p. 137).

Maintenance of Open Communication with Partner

The Breast Cancer Digest (1984) reported that "communication between partners appears to be the single most important factor in sexual and emotional adjustment to breast cancer" (p. 147). From diagnosis through the recovery phase, all the men in this study discussed being conscious of and working at maintaining mutual trust and open communication with their partners. They regarded these as particularly crucial to intimacy and sexual adjustment. Open expression of feelings enabled the men to more easily assume a supportive and nurturing role at that stage of the relationship. They reported that they mutually discussed varying feelings of shock, distress, anxiety, anger, and grief. Shared feelings resulted in greater spontaneity, emotional accessibility, and a means of exploring sexual and physical adjustments.

The stability of presurgery communication patterns between partners made it easier for them to share fears and feelings after the surgery. Only one man, who was closest to the surgery, reported any extended changes in his and partner's communication modality. ("She didn't want to talk about 'it' for several weeks after she came home from the hospital.") However, his efforts to supportively reach out to her eventually succeeded and became part of his coping process.

"How We Made It Through": A Point of View

The men shared a philosophical point of view about how they "made it through" the experience. They talked about previous life experiences that helped prepare them for the mastectomy experience, which, in turn, would help them to face other life crises. They talked about the inner resources (attitudes, values, and beliefs) that enabled them to focus on the positive ("If we can make it through this, my wife and I can make it through anything that comes along"), generating and mobilizing hope ("things will get better"; "I was determined we'd lick it together") while aware of what one man termed "the finiteness of life."

From their positve perspectives, the men regarded their coping abilitites as a cumulation of (a) maturing life experiences, (b) emotional commitment to the relationship, and (c) religious and moral values. Three men talked about life experiences and maturity in the following ways:

1. If we had been younger, we might not have handled things so well. Maturity helps. A relationship grows as you face positive and negative things together. I have more patience, I'm less rigid

> now than when I was younger. Experience and maturity help us to deal with life, lets you see someone else's side of things.
>
> 2. My philosophy in life is to adjust. The military took five years out of my life. I had no choice; we were at war. That kind of experience teaches you that you can't hide or run away. You have to face things head on. The difference is that when you're married you have someone to face things with you, like sick children or deaths in the family.
>
> 3. From experience you learn to deal with problems. A breast is a traumatic thing to lose, but not as traumatic as losing an arm or a leg. This wasn't something I could do anything about; she couldn't do anything about it either. We couldn't change it; we had to accept it and deal with it the same way we dealt with other problems we faced together.

Two men talked quite differently about the ways in which their work experiences influenced their abilities to cope with the surgery:

> 1. I was better able to deal with it than other males because I have to deal with problems every day in my business. Men [in his type of business] have to be sensitive to other people's responses, like a lay psychologist. We're better equipped to at least understand that if one approach doesn't work, lay off and try another.
>
> 2. I'm in the kind of work that involves people's feelings. I felt I could handle it [the surgery] because of the work I do, but it was more traumatic than I thought. There's a barrier of objectivity that keeps you effective professionally, but it's different when it involves you personally.

Two men ephasized the ability to commit to a close relationship as a coping factor:

> 1. We made a very real, very strong commitment to each other through sickness and in health. With a strong commitment, a strong relationship, you can cope with any kind of problem in life...I often

> wondered how I was going to cope with it all at the time; my philosophy is to just take one day at a time. Both of us are very adaptable individuals and have good coping mechanisms as opposed to falling apart.

2. It depends on what kind of relationship did you have before the surgery. Was it a loving, caring relationship? If it was, you're not going to have any trouble or any problems. It isn't going to be a problem unless you allow it to be and concentrate your thoughts on the lack of a breast; then that becomes as big as a mountain between the two of you. If your relationship was shaky in the beginning, I don't know how you're going to cope with it.

Two men felt their deeply meaningful religious beliefs sustained them through the experience. A third, who previously had talked about his commitment to the relationship, also talked about the importance of his religious upbringing in coping with difficult life situations.

1. Our faith in the Lord carried us though. Religion has a new meaning and substance for me. He has a time and place for all of us.
2. If I really believe, then this experience has shown me that I need to believe even more. I'm more committed than ever to my beliefs.
3. We were both raised in the same religion. It has a lot to do with the early formation of our characters. That religious upbringing tends to develop and strengthen one. Other adversities and traumas in life, such as my experience in the military, strengthens this ability to cope and not give up in despair.

The men's positive overview of their experience can be seen both as a coping mechanism (giving the crisis a place, meaning, in their lives) and as a sign of positive adaptation through the ability to incorporate the experience and grow from it. There may also be a kind of denial that works at this phase (recovery and postrecovery). Downplaying the painful aspects of the experience is a means of surmounting it in the service of the future, so that one can go on in one's life. The management of the stress and pain results in a hopefulness, which is expressed in this larger way of looking at the experience in the context of one's life, of life in general, and of mortality (special acknowledgement to Dr. Sylvia Sussman for this point).

The preceding section has described the men's coping behaviors; the following section will discuss how the men resolved and integrated the experience into their lives.

Resolution and Integration: Adaptational Outcomes

Heinz Hartmann (1958) developed the concept of adaptation, which he defined as:

> the functions which are more or less closely related to the tasks of reality mastery.
>
> Generally speaking, we call a man well adapted if his productivity, his ability to enjoy life, and his mental equilibrium are undisturbed. (pp. 22-23)

Lazarus and Folkman (1984) elaborated upon the adaptational outcomes of major stress encounters:

> Regardless of how they are defined or conceptualized, the prime importance of appraisal and coping processes is that they affect adaptational outcomes. The three basic kinds of outcome are functioning in work and social living, morale or life satisfaction, and somatic health. Simply put, the quality of life and what we usually mean by mental and physical health are tied up with the ways people evaluate and cope with the stresses of living. (p. 181)

From the men's perceptions of the impact of the mastectomy experience, two interwoven themes emerged. These themes reflected the successful adaptational outcomes resulting from their struggles through the painful encounter. The men talked about (a) how they had grown individually, both within themselves and within their conjoint relationships, and (b) how their conjoint relationships had grown both through closer bonding between the partners and affirmation of personal commitment and trust within the relationship.

Not surprisingly, two of the four men most recent to the surgery described themselves and their partners as "still adjusting" to the experience. In looking back at the overall effects of their experience, all nine subjects discussed how their conjoint relationships not only survived the breast cancer crisis, but were strengthened by the experience. Whereas six men, including the two "still adjusting," stressed the reinforcement of the actual bond itself, three emphasized how their wives' and their own individual personal growth strengthened the relationship following the surgery.

Personal Growth and Change

The three men within this subgroup were reflectively self-revealing about how both their wives' and their own individual personal growth in their adult years led to the resolution and integration of the mastectomy experience.

Two men were distant from the surgery, one close to it. One man had initially denied any fears of his partner's possible death; the second man's partner had had both breasts removed; the third man had been married the longest of all the subjects. Interestingly, all three were among the men whose marriages were of the longest duration (over 29 years). They talked about personal growth affecting changes within the postmastectomy relationship in the following ways:

1. In the last four years I've grown. I understand this period of growth isn't that unusual for someone moving into my age group, and reevaluation was sorely needed after she had the surgery. I can honestly look back and wonder why she put up with some of the immature actions I displayed in the past; how could she put up with all of that? Sundays, I loved my beer can and football games. She'd go to church with the kids. That is one example of what I now consider immaturity; not caring enough about my children's spiritual growth. At that time I was concerned with their physical and educational growth. But see, she's had a head start; there was so much more room for my growth. We feel now that she's kind of adjusted to the new me, and I can relate well enough to her that I can say that there's not been a better period in our marriage than right now.

2. If there's been a change in our relationship since the surgery, it's been in the direction of bringing us closer together, along with facing other life traumas. The first time she had the surgery, I was at a different place than now. I felt uncertain about my professional future, not in control of the [personal] situation, completely helpless and frustrated. It's different this time, because I'm a different person. I've grown a lot individually and in the marriage because of that first experience. Then, I think the women's movement has had a lot to do in changing men's perceptions. It's had it's effect on society as a whole and men as part of that society. My sons have grown up emotionally much faster than I; they

> are at stages of development that I didn't achieve until my forties. They can express themselves and their feelings in ways I wasn't comfortable with until I got over the problem men my age have about showing their vulnerabilities.

3. When we were younger, we were both ambitious, and it made the relationship stressful at times. I felt much closer to her after the surgery. She's a strong person. We sometimes joke about our strong personalities. The surgery made her more vulnerable, and I wanted to take care of her...She saw it as some kind of message that she'd better change her lifestyle...I became more supportive of her independence than resentful. I really accepted her change, whereas before I wanted her home to take care of me. I became more interested in household things and sharing the domestic scene...It [the surgery] attenuates what you have together. It reminds you that life isn't going to go on forever. You're continually reminded of the finiteness of life.

Growth of Relationship

Four men focused instead on how the surgery had strengthened the marital bond and had affirmed both commitment and trust that they could rely upon their partners in the event of their own serious injuries or illnesses. Three men distant from the surgery and one man more recent to it discussed this in the following ways:

1. It brought us even closer together, although we were close before the surgery; it makes people closer. It made me realize how important she is to me and how tenuous life is.

2. I think men get complacent and don't necessarily show their love for their wives [the longer they're married]. From that standpoint, it made us closer. I was complacent, taking things for granted; but the commitment was there all along. I love her as much now as when I married her, only now I tell her so. Mastectomy-so what?

3. When you reach mid-age, you're mature enough to handle it, to sit down and rationalize what's going to happen. It was one of our biggest traumas. It made a closer bond between the two of us, as we could sit down and talk about it. Living with a person for a long time, you get to know them well. There's a bond from being together and knowing each other so well. It [the surgery] just strengthened that bond in our relationship.

4. We faced this together, just as we did other problems that came up in our lives together. It changed her way of thinking; she saw it as a second chance at life, and I did, too. I knew she would always be there for me if something happened to me, and I knew she would have to go through more than me in accepting what had happened to her.

The two men who still considered themselves and their partners in the adaptive process also cited positive aspects of the experience. They reported:

1. In some ways we're even closer, because my feelings for her have stayed the same. I think she's depressed and tries to hide it. She's still afraid that how she looks could change things between us. I reassure her that she's still a good-looking woman, and that I love her. In some ways, it's really strengthened our relationship. If we can make it through this, nothing can hit us that could break us up.

2. She doesn't want to wait to do things. I've never taken a real vacation. When you own your own business, you settle for extended weekends. We took our first vacation in years...We have a good life together; we've achieved something pretty terrific that everyone strives for.

The men's responses clearly demonstrated that they did not view the mastectomy experience as hazardous to their marriages. This finding was supported by Nichols' (1978) master's thesis study, "Spouse Attitude Toward Mastectomy." One of his conclusions was:

> From the comments volunteered by the couples within the personal interviews and the questionnaires, the couples feel their relationships [marriages] were not jeopardized by the mastectomy. Many couples stated they felt their marriages had improved after the surgery. The above finding concurs with the literature in that quite often a solid marriage becomes better after the mastectomy. The crisis of the mastectomy joins the couple closer together which offers them an excellent support system. (p. 58)

Nichols' finding was also significant in relation to women's fears of abandonment following breast surgery. Next to fears of death and mutilation, the mastectomy literature indicates that mastectomees' greatest fear is that their conjoint relationships will deteriorate, leading to divorce or desertion. Future research needs to address how many marriages do in fact terminate after breast surgery and the role the mastectomy plays in the process. The mastectomy literature suggests the following two points of view: (a) These relationships may have been less solid to begin with, and the surgery was the catalyst affecting the break-up, or (b) the mastectomy may have provided the arena in which the couple's cumulative problems became focused.

The present study was designed to look at the male responses from the perspective of an ongoing relationship (of at least five years duration) that survived the surgery. The findings of the study suggested that the commonly held notion that men will leave their wives after mastectomy does not necessarily reflect reality. Rather than divisive, the men perceived the overall experience as having brought them closer to their partners and amplified their commitments to the relationship.

The men's adaptational outcomes met Mechanic's (1974) criteria for successful adaptation at the individual level: (a) They had the coping capabilities and skills to deal with the social and environmental demands to which they were exposed (b) they were motivated to meet the demands that became evident in their environments; and (c) they had the capabilities to maintain a state of psychological equilibrium, so that they could direct their energies and skills to meeting external, in contrast to internal, needs (p. 33).

CHAPTER VI

SUMMARY OF FINDINGS: DISCUSSION AND IMPLICATIONS

The concluding chapter compares the study findings with the initial assumptions and with other relevant research, discusses the implications for community and clinical services and for future research, and offers some final reflections.

Comparison of Findings with Initial Assumptions

Chapter III named five assumptions that underlay the present research. Three of these were borne out by the findings; two were not.

First, it was assumed that the mastectomy experience would involve each of the men in an extremely absorbing life crisis that would affect both his personal integration and his conjoint relationship. The men's stories revealed that this was true. It was also assumed that, in spite of individual differences, a common structure would be identified; that the experience would have a natural history. The data supported this assumption, and classified the issues the men faced during each sequential phase: diagnosis, hospitalization and surgery, and recovery.

Another assumption was that there would be a period of grief and mourning over the lost object (the breast).

However, the data showed that the fear of loss of the loved one was the transcending feeling at the initial (diagnostic) phase of the experience. A sense of loss of the (partner's) breast itself did not appear of major importance. Once the men knew that their partners had survived the surgery with favorable medical prognoses (hospitalization and surgery phase), the immense relief they felt seemed to mobilize them into a course of action that helped them determine their specific roles in their wives' recoveries. Yet there was a stage during the recovery phase when reestablishment of sexual intimacy became significant to the continuity of the relationship. Analysis of the interviews (chapters IV and V) has shown how these men felt about, conceptualized, and coped with that phase. Dealing with the loss of their partners' breast did not appear to be as vital as the reestablishment of shared closeness. However, as part of the process, the men revealed how they had to consider their wives' feelings: the sense of loss, depression, and damaged self-image.

It was assumed that the men's experience would reflect cultural attitudes and values ascribed to the female breast. The data did not support this assumption. None of the nine men felt their partners' breast loss diminished their femininity, desirability, or sensuality. Instead, they consistently indicated their primary concern for their wives' health and emotional recovery. The cultural influences did appear in the men's perceptions of their partners' feelings about the loss of the breast; the men felt their wives required frequent reassurance about their post surgical physical appearance and attractiveness. It would appear that the man's positive reinforcement of his partner's sexuality influences the woman's adjustment to her amputation. Nichols (1978) arrived at the same conclusion in his study, "Spouse Attitude Toward Mastectomy." He wrote, "The wife's emotional and physical adjustment after a mastectomy is directly related to the husband's acceptance of her new body image" (p. 58).

Common patterns of coping with the stress of an unpredictable crisis situation were expected; this assumption was supported. The data analysis revealed that the men used a common set of effective coping mechanisms, which were congruent with indicators of coping effectiveness. Those indicators were based on the observations of Visotsky et al. (1961), Hamburg and Adams (1963), and Lazarus and Folkman (1984).

Comparison of Findings with Other Relevant Research

This section will compare the findings with the issues the literature raises on mastectomy, on men's responses to their partners' breast cancer and surgery, as well as on coping with a spouse or loved one's life-threatening illness. Focus will be on the works of Wellisch et al.

(1978), Nichols (1978), Chodoff et al. (1963), Hamburg and Adams (1967), and Skelton and Dominian (1973).

The men in this study perceived that their overall experience had brought them closer to their partners and reinforced their commitment to their relationships. The crisis of mastectomy and the experience of coping and adaptation that ensued seemed to strengthen the bond between the partners. Maintenance of open communication and reestablishment of sexual intimacy was a part of the process. Nichols (1978) had similar findings; the couples he interviewed did not feel their marriages jeopardized by the mastectomy. In fact, "Many couples stated that they felt their marriages had improved after the surgery" (p. 23). However, Wellisch et al. (1978) found that over one-third (35.7%) of the 31 men in their sample thought that intimacy and sexuality in their relationships had been "severely stressed and often negatively altered" after breast surgery. Their finding "correlated significantly" with their subjects' general evaluation of the relationship: the higher the men's assessments of the relationship, the less negative the mastectomy's influence (p. 544). Both the findings of the present study and the Wellisch et al. data clearly suggest that a solid and emotionally rewarding preoperative relationship generally transcends the difficulty of adjusting to this crisis.

Skelton and Dominian (1973) also confirmed this finding. In their study concerning wives' psychological responses to their husbands' heart attacks, they reported: "The impact of the illness appeared to depend on the quality of the marital relations before its onset" (p. 102).

Men face specific issues that relate to their cultural identity as "the strong one." Those in the present study experienced the dilemma of how to "be strong" for their partners while dealing with their own fears and anxieties about losing their partners. In Skelton and Dominian's study, the women's problems with their husbands' myocardial infarctions also reflected gender differences.

The subjects in both studies initially experienced the same shock and numbness at the onset of their partners' illness. Hamburg and Adams (1967) reported this same kind of reaction in parents of terminally ill children. After a year, Skelton and Dominian (1973) found that the wives' fears and anxieties had decreased, with only 8 of 65 women showing "poor adjustment" when the husband had made a positive physical recovery. The present study findings indicated that the men, too, were able to integrate the mastectomy experience into their lives. Thus the subjects in the two studies "made it through" their respective experiences.

However, gender differences did bring up substantially different issues and problems. Although both the male and female subjects feared the loss or death of their partners and recurrence of the illness, the women experienced guilt, depression, and marital tensions that the men in the present study did not report. In assuming the role of "the strong one," the men dealt with their anxiety by keeping busy, moving from anxiety-induced passivity to constructive activity. In effect, the men were denying their dependency needs by "easing her burden" and focusing on their partners needs. In contrast, the women's marital tension resulted from their partners' increased dependency and irritability. The women were in a bind: If they showed concern, their husbands accused them of being "over-protective and smothering"; if they showed less concern, their husbands viewed them as uncaring. At the same time, some of the women felt they had lost the "strong husband" they had and would "never feel safe again" (p. 102). These women were depressed because of their own unmet dependency needs; they felt guilty that they had not more carefully monitored their husbands' work and health habits. Skelton & Dominian (1973) did not explore the women's specific coping methods. However, just as their issues and problems differed from the men's in this study, their coping methods probably also differed . Comparison of these findings does indicate that both the male and female subjects in the two studies were able to adapt to the crisis of their partners' unpredictable, life-threatening illness. Both studies emphasize the crucial impact spouses' emotional attitudes and ability to cope have on their partners' recuperative process.

This study's finding that the men kept busy with constructive activity was also supported by Chodoff et al. (1963). They found motor activity served as an important adaptive device for the parents in their study, both for direct coping (keeping busy) and for defensive purposes (containing anxiety). Unlike the defenses of denial and isolation of affect, which the authors identified as primary defense mechanisms, "motor activity was more likely to be a consciously determined strategy, generally accompanied by a determined and deliberate suppression of negative feelings" (p. 746).

Although all but two of the men in the present study reported initial aversion to the wound site, the findings suggested that this initial response did not last long. All nine men were able to accept their partners' altered body image and resume sexual closeness. Yet it is important to consider the issues raised by the mastectomy literature regarding the aversion response. Bard and Sutherland (1955) attributed aversion reactions to the projection of the male's own fears of illness and amputations, his even phobic reactions to body injury. Schoenberg and Carr (1970) observed that when a man's anxiety over mutilation is great, "he is likely to react to his wife's mutilation with avoidance or repulsion" (p. 127). Comfort (1978) summarized that the men's range of responses included irrational rejection, denial of rejection, and projection of their embarrassment. However, Comfort concluded that "male reactions are often more concerned and reticent than rejecting" (p. 224). Wellisch et al. (1978) did not report upon the men's reactions to the incision area. Rather, they focused upon the decision to view the incision site. They found that the decision not to look at it was often the male's, rather than the female's choice. The men in this study, however, all viewed the scar soon after the surgery. The act of viewing replaced imagined or fantasized images with reality. As one subject commented, "After a few weeks, it's no big deal."

The data of this study revealed that each man had a philosophical point of view about "how we made it through" the experience. This point of view was based upon each man's perceptions of his inner resources (attitudes, values, beliefs) and the previous life experiences that enabled him to cope with the stress and mediate the emotional behavioral, and environmental demands of the situation. This kind of perspective seemed to be a way for the men to integrate the experience into their lives in a strengthening and meaningful way. Chodoff et al. (1963) also discussed this need to give "meaning" to the experience in their observations of parents of fatally ill children. They referred to the parents' "search for meaning," their strong need to find an encompassing framework that could make their personal situations more tolerable. Chodoff et al. wrote that the parents exhibited "one particular aspect of a universal, even existential hunger for a meaningful and understandable explanation of seemingly indifferent events" (p. 747). This philosophical perspective that Chodoff et al. observed in the parents' coping process was equally important in the men's coping process.

Hamburg and Adams (1967) focused their research on the ways "normal" people cope with "the threatening implications of difficult transitional experiences" (p. 277). In summarizing their studies of coping with serious illness and injuries, they found most of their subjects "remarkably resourceful even in the face of a catastrophic situation. Most of them showed an impressive resiliency and ability to work out new patterns of living" (p. 278). The men in the present study fit this description.

Implications for Community and Clinical Services

An increasing number of comprehensive programs for women facing or recovering from breast cancer surgery exist throughout the country. From the Memorial Sloan-Kettering Cancer Center in New York City and the Albert Einstein Medical Center's Breast Cancer Program in Philadelphia to The Breast Center in Van Nuys, California and The Postmastectomy Project at Stanford University in California, such programs offer a variety of presurgery and rehabilitative support services for breast cancer patients and, to some extent, their families. Most individual communities now offer women the services of Reach to Recovery, the American Cancer Society's volunteer visitor program, and Encore (encouragement, normalcy, counseling, opportunity, reaching-out, energies revived), the national YWCA-sponsored exercise and educational program. However, as was learned through this study, few services specifically address the particular needs of the male partner during the experience. Other than Reach to Recovery's addition of male volunteers, the availability of external support systems is minimal at the local community level. After the male partner has been included in the medical decision-making process during the diagnostic phase, he is on his own to appraise and cope with the issues that arise.

The findings of the present study indicated that the subjects did not require direct clinical crisis intervention. In his 1978 study, "Spouse Attitude Toward Mastectomy," Nichols also found that the couples' overall responses did not specify the need for mastectomy crisis intervention. Clinical treatment is sought usually when or if the female partner experiences difficulty with her grief reaction, sexuality, body image, or communication issues during the recovery phase. At that time she may seek individual or group treatment, or she may involve her husband and/or family members either in conjoint or family therapy.

Although the men in this study did not require professional clinical intervention, it is important to address the following questions: (a) Do men need support services for themselves? (b) If so, what kinds? (c) When should these be made available? The data analysis showed that the men were divided about seeking and receiving personal support. Four men emphatically denied the need for any nurturant support sources other than family members and close friends. Yet five men felt, "Something else is needed," "Men just aren't prepared for the psychological aspects," and "It's important to know what you're up against." As one man close to the surgery commented at the end of the interview, "You know, within two weeks after the surgery, there should be a film available for husbands about what to expect and ways to deal with it, because nothing prepares you for it."

From the study findings, it would appear that at least half of the men would have made use of a service that would have helped prepare them for the recovery phase. The advantage of a film or videotape is that the men would have considered this an educational, informative service focused upon helping their partners, rather than an intrusive one that threatened their self-concepts as men in charge of their own feelings. The study findings also suggested that the most propitious time to make a videotape available is during the hospitalization and surgery phase: for pragmatic reasons, because the men are frequently in the hospital for partner visitations; for emotional reasons, because they are facing the reality of the surgery, and they are going to have to deal with many unknowns in the recovery process. Because one of the purposes of this study was to find out what kinds of services the men thought were needed in their community and then to develop and implement them, the author has formulated a proposal for a film or videotape presentation for men's viewing during the hospitalization and surgery phase.

Implications for Future Research

As stated at the beginning of this study, breast cancer is not solely a "woman's problem." Rather, it affects every member of the basic or nuclear family constellation as well as extended family and close friends. This study concerned only the male partner, who, after the mastectomee, is the family member most profoundly affected. Therefore, future research must explore the effects of breast surgery on other family members.

Considering the fears young children experience of separation and abandonment from the primary nurturing person, studies need to further investigate the impact of mastectomy on those under 6 years of age, as well as those between 6 and 12 years, who also need the stability of the primary nurturing relationship. Because adolescents are in the process of symbolically separating from the family, it is necessary to look at how breast surgery affects the adolescent girl's relationship with her mother and her fears about developing the disease itself. At the same time, little is known about how breast cancer affects the adolescent boy's struggles with his own increasing sexual awareness and activity.

Future studies need to address how many marriages terminate after breast surgery and the role the mastectomy plays in the process. Because there is no empirical or statistical evidence to indicate that the surgery leads to abandonment or rejection, it is particularly essential that this "myth of mastectomy" be investigated, allowing for the difficulty involved in recruitment of divorced male subjects.

This study's findings indicated that the "other partner" in the mastectomy experience is often overlooked, because the major focus of concern is upon the stricken partner. Therefore, it is hoped this study will ignite the curiosity of other researchers interested in what the "other partner" goes through in coping with such life-threatening illnesses as heart attacks, cancer, and AIDS, as well as such major life crises as rape, abortion, and divorce and child custody conflicts.

The findings of this study also raise implications for specific further research on men's reponses to their partners' mastectomies. Larger populations containing a more varied socioeconomic sample need to be explored, especially those containing low-income, little-educated, or minority men. We know very little about how Hispanic-American, Asian American, and black men deal with this major crisis.

One significant finding was that solid presurgery relationships survived the mastectomy crisis. The men in this study had the advantage of middle age maturity or "mellowing." But what are the effects of mastectomy on younger men recently married or cohabitating? How do they deal with their partners' health crisis?

Because this study was based on men's reflective responses, longitudinal studies still need to be done, in which the men are interviewed at specific phases of the experience: at 3 months (acute crisis period); at 9 months (partners' recovery period); and at 2 years (integration period). These studies would provide a more comprehensive picture of the issues and dilemmas the men face and the actual ongoing coping and adaptation process.

The findings showed that men from 8 months to 3.5 years after the mastectomy had different responses than those more distant from it. They talked in more detail about their partners' difficulties and struggles and their own pain.

Thus the findings suggest that future studies should focus on men recent to the surgery, but beyond the acute crisis (from 6 months to 3 years beyond surgery). By exploring a limited population of such men, more precise issues, dilemmas, and coping strategies would be revealed about the impact of mastectomy.

Further studies of men with some distance from the surgery would give us more understanding of how men incorporate such a crisis into their lives. Very little work has been done on the issue of the meaning of an experience and how "giving of meaning" itself is an important psychological process. This study has suggested the concept "how we made it through." Others have discussed the "search for meaning" (Chodoff et al., 1963), and coping theory suggests the person's need to maintain a sense of continuity of self before, during, and after a crisis. Such research could not only add to our understanding of how normal people integrate crises into their lives, but would also contribute to our understanding of adult development.

The present study's emphasis on the mastectomy crisis focuses on two issues. One, as mentioned above, is the problem of managing a life crisis. The other speaks directly to mastectomy and what we have yet to learn about the impact of this specific ordeal on a life. In particular, our concern is to further research on the male partner's experience.

Final Reflections on the Study

The study interviews took place in the interviewer's office rather than in the men's homes or places of business. This was planned because it is easier to make interviewees comfortable within one's own environment than in the subject's, where the unexpected distractions of phones, children, secretaries, or curious spouses are likely. Therefore, all the interviews, except one, were conducted in the same neutral, nonthreatening, nondistracting setting. The men could feel at ease and ask questions as the interview procedures were introduced and the forms were presented, discussed, and signed. In other words, the interviewer had control over the external surroundings and the interview content to be covered within the specified hour and a half. Yet the men were free to respond to, elaborate upon, or simply bypass areas they did not feel to be relevant. In this sense, the men were the teachers and the interviewer the learner.

Two areas important to a clinician were incorporated into the design of the interview guides, reflecting the interviewer's clinical orientation. One related to previous losses (parents, family members, friends), and one related to somatic reactions at the time of their wives' surgery (changes in sleep, eating patterns, the use of alcohol or tranquilizers). Although all the questions were introduced in each interview, the men's responses soon made evident which areas were significant to each of them. Because they were not clinicians, they were not aware of possible connections between past losses or deaths in their families and their reactions to their partners' mastectomies. The men did not dwell upon previous loss experiences; they were focused on the "here and now" and looking ahead.

A mostly middle-aged group, the men were concerned about their own and family's health and physical activity. Most of them had regular exercise programs ranging from baseball to jogging. However, they did not put much emphasis on somatic expressions of stress. They did not expand upon somatic reactions during their partners' hospitalization as other than temporary changes. Their emphasis was upon surviving an ordeal that deeply affected them and their ways of looking at the world.

Most appeared somewhat formal as they first appraised the interview situation. After 10 or 15 minutes, they visibly relaxed and became open and candid about their experiences. Some men were more articulate and spontaneous, while others needed the probe questions to maintain the interview flow. Certain of their responses added to the validity of the study. Their candor about crying at the time of diagnosis, their aversion reactions to viewing the wound site, and their finding "other erotic areas" for love play and arousal indicated they were not hiding things they considered negative or embarrassing.

These middle-class men with fairly conservative values seemed to be caretakers of their own emotions. Although our society is questioning such traditional male roles as "the strong one" and "the breadwinner and provider," the men's self-images of "being strong, being busy, and being there for her" served them well through the mastectomy crisis. They not only "made it through" the experience, but felt they had emotionally benefited from it.

APPENDIX A

CALIFORNIA INSTITUTE FOR CLINICAL SOCIAL WORK

Proposed Procedures For Participation and Protection of Human Subjects In Research

The attached materials demonstrate these procedures. They include:

1. Introductory letter sent to subject
2. Informed consent statement
3. Nondirective pilot study and semistructured interview guides, including:
    a. An explanation of the procedures to be followed;
    b. A description of possible discomforts and risks;
    c. An offer to answer any questions about the procedures;
    d. An instruction that subjects are free to withdraw their consent and to discontinue the participation in the investigation at any time without prejudice or penalty; and
    e. A statement that the research procedures have been approved by the dissertation committee at CICSW.
4. Personal information form (all responses optional)

Introductory Letter to Subjects

Date:

Mr. ______________________

Address: ________________

Dear Mr. ________________

For some time I've been interested in finding out, through research methods, what men experience when their partners have had a mastectomy. Much of the research done in the area of breast cancer tends to overlook the integral part male partners have in a woman's recovery/adjustment to her physical and emotional loss.

I am currently in the process of interviewing for my Ph.D. dissertation at the California Institute for Clinical Social Work, Berkeley, California. I am writing to ask if I could interview you for about one and a half hours.

In sharing your thoughts and feelings about what you experienced, we may begin to understand some of the unique dilemmas men have to deal with when their loved ones are undergoing the process of tumor discovery, surgery, mourning, and recuperation. Hopefully, the results of this study will be helpful to other men facing the uncertainties involved with their partners' mastectomies.

The interview will be voluntary and confidential. No names or individual identifying information will be used in any oral or written materials.

I will call you during the week of ________________ after 7:00 p.m. to answer any questions you may have. At that time, if you are willing to participate, we can schedule a time and place for the interview that will be at your convenience.

Sincerely,

(Ms.) Thea Diste Wilson,
L.C.S.W., M.F.C.C.
Licensed Clinical Social Worker
Licensed Marriage, Family, and
Child Counselor

CALIFORNIA INSTITUTE FOR CLINICAL SOCIAL WORK

Informed Consent Statement

I, ________________________________, hereby willingly consent to participate in the research project, Men's Psychosocial Responses to Their Partners' Mastectomies (working title) under the direction of Sylvia Sussman, Ph.D., Faculty, C.I.C.S.W.

I understand that I may withdraw from the study at any time without penalty. I understand that this study may be published, and that my anonymity will be protected unless I give my written consent to such disclosure.

Date: ________________________

Signature: ____________________

Witness: ________________________

Research Subject's Personal Information Form

(All responses are optional: Please complete only those questions you wish to answer)

Today's date__________

Name:________________________ Telephone: Home__________

Work__________

Address:______________________________ Zip Code__________

Date of Birth:_______________

Occupation: (Describe briefly your job and position, the type of work you do and roughly how many hours you work you do and roughly how many hours you work per week.)

____

Your spouse/partner's occupation: (Please follow the same instructions as above.)

____

Number of years in current relationship/marriage:__________

Children: (Please list the sex, ages, and indicate whether still in the home.)

____

Please list number of previous marriages:_________________

Duration and year terminated:____________________________

Children of previous marriages: (Please list their sex and ages. If under 18, please list with whom and where geographically living.)

____

Number of years since partner's mastectomy:_______________

Please list your parents' ages (or age at death):

Mother:__________

Father:__________

Please list the sex and age of brothers and sisters living. (If not living, please indicate age at death.)

____

What is the highest grade you completed in school?________

What is your religion?________________________________

What is your ethnic background?___________________________

APPENDIX B

Nondirective Pilot Study Interview Guide

Introduction

I want to first express hwo much I appreciate your being here and taking the time to help me with my research study.

As I indicated in my letter and when we talked over the phone, I'm interested in what men experience, go through, when their partners have had a mastectomy. I'm especially interested in how you saw yourself in the situation: your thoughts, feelings, and responses, from the time the tumor was discovered through your partner's surgery, during the first months after, and now. We can move in any direction that's meaningful to you. The questions I ask are to help me understand what you are telling me.

I'm going to ask you to read this Informed Consent Statement, which describes the voluntary and confidential nature of the study, as well as your right to withdraw from it at any time without penalty or prejudice. It also indicates that these procedures are under the faculty direction of my dissertation committee chairperson and have been approved by my research committee. Please sign it if you are in accord with its content.

At the end of the interview, I'll ask you to complete a Personal Information Form. Your responses are optional, and you need only answer those questions you wish. Now, are there any questions I can answer that may clarify what we're going to be doing together for the next hour and a half?

Where would you like to start? (If subject doesn't initiate beginning discourse, interviewer would proceed) . . . Perhaps we could start with the present, right now. What things came to mind when you thought about this interview? (What things did you think important to talk about? . . . How did this all start for you?)

(The following open-ended and related probe questions are interchangeable, with the interview flow moving back and forth between these general areas rather than in the sequential order listed.)

General Open-Ended and Related Probe Questions

1. Internal Structural Reactions. How did all this start for you? (How did you find out that your partner was going to need breast surgery?) What were your first reactions? (Thoughts, feelings . . . What did you say, do?) What about your partner's reactions to the diagnosis? (What were her major thoughts and feelings? How did you deal (not deal) with all this at the time? Can you recall any other situations in your life that caused similar reactions? Our society is very concerned about physical attractiveness. How did you find yourself responding to your partner's body change, the loss of her breast after surgery? What was the most stressful time for you during the mastectomy process? (Pre or postsurgery, hospitalization, six months after surgery, a year, now? How did you get through it?)

2. External/Behavioral Responses. How were you able (unable) to communicate/demonstrate what you were thinking and feeling to your partner? (How were you able (unable) to offer/show support . . . in the home . . . with the family . . . socially? How did you handle all this with the children? What kinds of adjustments did you have to make?) When did you resume your sexual relationship? (How did you approach each other about love making after the mastectomy?) What effect do you think the mastectomy has had on your sexual and intimate relationship? (Do you think it's changed, remained the same, better, worse?)

3. Previous and Childhood Experiences. How did your family view health and sickness when you were growing up? (What kinds of major health problems/injuries did anyone in your family have . . . mother . . . father . . . sisters . . . brothers . . . extended family? How did your family respond . . . deal with it? How did it change or affect the family?) What's been your own health history? What was your first introduction to a friend or loved one's serious illness or death?

4. Reflective Insight/Integration. What's the quality of your relationship with your partner now? (What's different, what's the same, what's changed since the mastectomy?) Would you have done anything differently during your partner's recovery/adjustment process? (What expectations did you feel your partner or others had of you that you did (didn't) fulfill? What were your major frustrations?) What sort of personal support was available to you? (Who of your friends or family could you turn to or talk with?) What kinds of support were the most useful? (the least?) What would you consider the most important things you would pass on to other men and women facing a similar ordeal?

Conclusion: Further comments and questions about the interview. Completion of Personal Information Form.

APPENDIX C

Semistructured Interview Guide

Introduction

I want to first express how much I appreciate your being here and taking the time to help me with my research study.

As I indicated in my letter and when we talked over the phone, I'm interested in what men experience, go through, when their partners have had a mastectomy. Much has been written about the psychosocial and physiological trauma women experience with breast surgery--their fear of death, fear of disfigurement of the body, loss of sexual attractiveness, and loss of societal and self-esteem. However, few studies have attempted to explore the role of the male partner, the person usually closest to the mastectomee.

In this pioneering effort to explore breast surgery from the male's perspective, I'm enlisting your help to learn about what it is and was like, the impact it's had on you, and how you dealt with this ordeal in your personal life. I will ask you a number of questions relating to this experience: how it affected you, your relationship with your partner, the other members of your family; what things are different and which remain the same, including sexual and intimate areas of communication.

Perhaps together we can begin to discover some of the major dilemmas men face and experience, as well as ones unique to you--what you've learned about yourself and partner in the process.

First, I'm going to ask you to read this Informed Consent Statement, which describes the voluntary and confidential nature of the study, as well as your right to withdraw from it at any time without penalty or prejudice. It also indicates that these procedures are under the faculty direction of my dissertation committee chairperson and have been approved by my research committee. Please sign it if you are in accord with the content.

At the end of the interview, I'll ask you to complete a Personal Information Statement. Your responses are optional, and you need only answer those questions you wish.

Now, are there any questions I can answer that may further clarify what we're going to be doing together the next hour and a half?

Semistructured Interview Questions

A. Anticipatory Stage: Discovery and Diagnosis of Tumor

1. How did all this start for you? (How did you first find out your partner had a lump or tumor in her breast?)
2. Could you describe your first reactions? (What did you feel, say, do?)
3. What about your partner's reactions to the diagnosis? (What were her main fears and feelings? How did you deal with all this at the time?)
4. Some physicians talk with the couple together or separately before the surgery. What was your experience with the surgeon? (Did he include you in presurgery planning, did you feel left out? How did this increase or lessen your concerns?)

B. Operative State: Surgery and Hospitalization

1. How or with whom did you spend your time while your partner was hospitalized? (Alone, with family, friends, working?)
2. How would you describe your emotional state during that time? (Any changes in your eating, sleeping, drinking, smoking, work habits? Use of tranquilizers?)
3. While your partner was in the hospital, did the physician or hospital staff members talk with you (your partner, together) about any of the adjustments to expect after mastectomy (physical, emotional, sexual)?
4. Was this helpful? In what ways? (If not discussed, would it have been helpful? In what ways?)

C. Reparative Stage: Recuperation

1. What changes did you have to make in the household routine when your partner came home? (Did you find yourself doing a lot extra? Was it a burden? How long was the regular routine upset? Are the changes permanent or are things back to normal?)
2. How was your partner's surgery handled with others? (What did you share with the children, extended family, friends, neighbors, people at work?)

D. Communication and Support

1. How would you describe your relationship with your partner before the mastectomy? (What were your chief satisfactions? What were the problem areas?)
2. How were you able to show your support after surgery? (How did you respond to her signs of emotional ups and downs?)

3. What was the time of greatest emotional stress for you? (Pre or postsurgery, hospitalization, six months after surgery, a year, now? For your partner?)
4. How did you get through this time of stress?

E. Quality of Relationship

1. What are the differences in your relationship since the surgery? (What's changed, what's stayed the same?)
2. Would you have done anything differently during your partner's mastectomy process? (What expectations did you feel your partner or others had of you that you did or didn't fulfill? What were your major frustrations?)
3. Overall, what was the biggest adjustment you had to make? (Has it strengthened or weakened the relationship?)

F. Intimate and Sexual Relationship

1. Our society is very concerned about physical attractiveness. How did you find yourself responding to your partner's body change, the loss of her breast? (Initially, later, now?)
2. Did you have any concerns about resuming your sexual life together? (Were you worried about hurting her, did she seem more fragile, were you less aroused?)
3. How did you approach each other about lovemaking after the surgery? (Who made the first overture? Was this typical of your past relationship, different?)
4. When did you first view the wound site/scar? (in the hospital, at home? How did this come about? Was it your decision or hers to initially view the incision site?)
5. What effect do you think the mastectomy has had on your intimate and sexual relationship? (Do you think it's changed, the same, better, worse? Do you feel closer, further apart?)

G. Personal Support Systems

1. What sort of personal support did you have; who was there for you? (friends, family members, co-workers; how did they help?)
2. Aside from relatives and close friends, what resources were available in the community? (Church, family doctor, another male partner who had been through the experience?)
3. What helped the most? The least? (Any negative experiences: people you couldn't count on, thoughtless remarks, nosey questions?)
4. What kinds of community resources do you think would have been helpful?
5. What are the most important things you would pass on to other men facing a similar ordeal?

H. Previous Losses and Illness or Death Experiences

1. What's been your previous experience with major health problems/injuries in your family? (partner(s), children) When you were growing up? (Parents, siblings) (How old were you at the time. What kind of impact did it have on you then? Now?)
2. Are your parents still living? (What is the state of their [his,her] health?)
3. What's been your own health history? (past, recent)
4. What was your first experience with a friend or loved one's serious illness or death? (vignette?)

I. Women's Basic Fears of Mastectomy

1. Some research has indicated that most women's first basic fear of mastectomy is that of death. What's your point of view about that finding?
2. Other research has shown that many women fear they are physically unattractive and not sexually desirable after a mastectomy. What are your thoughts about that?
3. Some studies also show that many women fear their relationship with their male partners will fall apart, that they will be rejected. I'm certainly interested in your opinion about that conclusion.

J. Closure

1. Do you have anything further to add? Is there anything important we've left out?
2. Do you have any questions or comments about the interview itself?

Completion of Personal Information Statement.

APPENDIX D

Interview Coding Form

The following outline was used for each topic in the semistructured interview guide (transposed onto 10 x 12 index cards).

Example

Topic Area A: Discovery and Diagnosis of Tumor

1. Specific incidents and/or responses described:
    a. How did all this start for you?

    b. First reaction(s)?

    c. Partner's reaction(s)?

    d. Experience with surgeon?

2. Summary of topic area content: major themes, secondary themes, new information

3. End-of-interview summary

   Summary of overall interview content: overall major themes, secondary themes, new information (comments, reflections, points of view)

4. Comparison with previous interview content: ranges of responses, dimensions, pronounced or minimized responses, relationships among categories (similarities and differences), central themes and meanings

5. Ideas emerging from data: new or collapsed categories, abstracted theoretical notions, integration of comparisons

Bibliography

Abrams, R. D., & Finesinger, J. E. (1953). Guilt reactions in cancer patients. *Cancer*, *6*, 474-479.

Asken, M. J. (1975). Psychoemotional aspects of mastectomy: A review of recent literature. *American Journal of Psychiatry*, *132*, 56-59.

Avery, C. (1984, July 15). Mastectomy. *The Sacramento Bee*, pp. 3-4.

Ayalah, D., & Weinstock, I. J. (1979). *Breasts: Women speak about their breasts and their lives*. New York: Summit.

Bahnson, C. B. (1977). Psychological and emotional issues in cancer: The psycho-therapeutic care of the cancer patient. *Seminars on Oncology*, *2*(4), 293-309.

Baker, R. R. (1977). *Current trends in the management of breast cancer*. Baltimore: Johns Hopkin University Press.

Bard, M. (1952). The sequence of emotional reactions in radical mastectomy patients. *Public Health Reports*, *67*(11), 1144-1147.

Bard, M., & Sutherland, A. M. (1955). Psychological impact of cancer and its treatment. *Cancer*, *8*, 656-672.

Bardwick, J. (1971). *Psychology of women: A study of bio-cultural conflicts*. New York: Harper & Row.

Barton, D. (1977). *Dying and death: A clinical guide for caregivers*. Baltimore: The Williams & Wilkins Company.

Bennetts, L. (1982, March 1). Breast cancer and sexuality. *New York Times*, p. 138.

Berelson, B. (1952). *Content analysis in communication research*. New York: American Book-Stratford Press.

Berelson, B. (1954). Content analysis. In G. Lindzey (Ed.), *Handbook of social psychology: Vol. 1*. Reading: Addison-Wesley, pp. 488-522.

Blumenfeld, E. S. (1983). *The study of a woman's college class thirty years later: Maturity in middle-aged women*. Unpublished doctoral dissertation, California Institute for Clinical Social Work, Berkeley, CA.

Bowlby, J. (1969). Attachment and loss: Attachment (Vol. 1). New York: Basic Books.

Bowlby, J. (1973). Attachment and loss: Separation (Vol. 2). New York: Basic Books.

Bowlby, J. (1980). Attachment and loss: Loss (Vol. 3). New York: Basic Books.

The Breast Cancer Digest (1980). (NIH Public Health Service publication No. 81-1691) (1st ed.) Bethesda, MD: National Cancer Institute.

The Breast Cancer Digest (1984). (NIH Public Health Service publication No. 81-1691) (2nd ed.) Bethesda, MD: National Cancer Institute.

Bullard, D. G., Cansey, G. G., Newman, A. B., Orloff, R., Schanche, K., & Wallace, D. H. (1979). Sexual health care and cancer: A needs assessment. Frontiers of Radiation Therapy and Oncology, 14, 55-58.

Cancer facts and figures, 1982. (1982). American Cancer Society.

Caplan, G. (1964). Principles of preventive psychiatry. New York: Basic Books.

Cartwright, D. (1980, May). All about breasts. Cosmopolitan, 290-294.

Chodoff, P., Friedman, S., & Hamburg, D. (1963). Stress, defenses, and coping behavior: Observations in parents of children with malignant disease. American Journal of Psychiatry, 120, 743-749.

Clark, A. (1980). A heuristic model for exploratory research. The Humanistic Psychology Institute Review, 2 (2).

Cohen, F. & Lazarus, R. S. (1973). Active coping processes, coping dispositions, and recovery from surgery. Psychosomatic Medicine, 35, 375-389.

Comfort, A. (Ed.) (1978). Sexual consequences of disability. Philadelphia: George F. Stickley.

de Araujo, G., van Arsdel, P., Jr., Holmes, T. H., & Dudley, D. L. Life change, coping ability and chronic intrinsic asthma. Journal of Psychosomatic Research, 17, 359-363.

Denzin, N. K. (1970). The research act in sociology: A theoretical introduction to sociological methods. Chicago: Aldine.

Dimsdale, J. E. (1974). The coping behavior of Nazi concentration camp survivors. American Journal of Psychiatry, 131, 792-797.

Emerson, M. B. (1985). The impact of geographic relocation of married, career women; A study in social exchange theory and coping theory. Unpublished doctoral dissertation, California Institute for Clinical Social Work, Berkeley, CA.

Erikson, E. H. (1950). Childhood and society. New York: W. W. Norton.

Ervin, C. V. (1973). Psychological adjustment to mastectomy. Medical Aspects of Human Sexuality, 7, 42-65.

Fisher, S., & Cleveland, S. (1958). Body image and personality. Princeton, N.J.: Van Nostrand.

Folkins, C. H. (1970). Temporal factors and the cognitive mediators of stress reaction. Journal of Personality and Social Psychology, 14, 173-184.

Folkman, S. & Lazarus, R. (1980). An analysis of coping in a middle-age community sample. Journal of Health and Social Behavior, 21 (3), 219-239.

Folkman, S., Schaefer, C., & Lazarus, R. S. (1979). Cognitive processes as mediators of stress and coping. In V. Hamilton & D. M. Warburton (Eds.), Human stress and cognition: An information-processing approach. London: Wiley.

Franklyn, R. A. (1976). Augmentation mamaplasty. Rome: International Academy of Cosmetic Surgery.

Freud, A. (1937). The ego and the mechanisms of defense. London: Hogarth Press.

Gaylin, W. (1976). Caring. New York: Alfred A. Knopf.

Georgiade, N. G. Breast reconstruction following mastectomy. St. Louis: C.V. Mosby.

Glaser, B. G. (1965). The constant comparative method of qualitative analysis. Social Problems, 12, 436-445.

Glaser, B., & Strauss, A. (1967). The discovery of grounded theory: Strategies for qualitative research. Chicago: Aldine.

Goffman, E. (1963). Stigma: Notes on the management of spoiled identity. Englewood Cliffs, NJ: Prentice-Hall.

Gorman, W. (1964). Body words. The Psychoanalytic Review, 51(1), 21-25.

Gottesman, D., & Lewis, M. S. (1982). Differences in crisis reactions among cancer and surgery patients. Journal of Consulting Clinical Psychology, 50, 381-388.

Gottschalk, L. A. & Glaser, G. (1969). The measurement of psychological states through the content analysis of verbal behavior. Berkeley: University of California Press.

Grandstaff, N. W. (1975). The impact of breast cancer on the family. In J. M. Vaeth (Ed.), Breast cancer: Its impact on the patient, family, and community. Proceedings of the 11th Annual S.F. Cancer Symposium.

Green, C., & Mantell, J. E. (1978). The need for management of the psychosexual aspects of mastectomy. In A. Comfort (Ed.), Sexual consequences of disability. Philadelphia: George F. Stickley.

Green, C., & Mantell, J. E. (1978). Reducing postmastectomy dysfunction: An appropriate role for social workers. In A. Comfort (Ed.), Sexual consequences of disability. Philadelphia: George F. Stickley.

Grinker, R. R., & Spiegel, J. P. (1945). Men under stress. New York: McGraw-Hill.

Haan, N. (1969). A tripartite model of ego functioning: Values and clinical research applications. Journal of Nervous and Mental Disease, 148, 14-30.

Haan, N. (1977). Coping and defending: Processes of self-environment organization. New York: Academic Press.

Hamburg, D., & Adams, J. (1967). A perspective on coping behavior: Seeking and utilizing information in major transactions. Archives of General Psychiatry, 17, 277-284.

Hamburg, D., Artz, C., Reiss, E., Amspacher, W. H., & Chambers, R. E. (1953). Clinical importance of emotional problems in the care of patients with burns. The New England Journal of Medicine, 248 (9), 355-359.

Hamburg, D., Hamburg, B., & deGoza, S. (1953). Adaptive problems and mechanisms in severely burned patients. Psychiatry, 16, 1-20.

Hancock, E. (1981). Women's development in adult life. Unpublished doctoral dissertation, Harvard University.

Harrell, H. C. (1972). To lose a breast. American Journal of Nursing, 72, 676-677.

Hartmann, H. (1958). Ego psychology and the problem of adaptation. New York: International Universities Press.

Hollis, F. (1967). Explorations in the development of a typology of casework treatment. Social Casework, 48 (6), 335-341.

Hollis, F. (1967). The coding and application of a typology of casework treatment. Social Casework, 48, (6), 489-491.

Ilfeld, F. (1980). Coping styles of Chicago adults' effectiveness. Archives of General Psychiatry, 37(11), 1239-1243.

Jacques, E. (1965). Death and the mid-life crisis. International Journal of Psychoanalysis, 46, 502-514.

Jamison, K. R., Wellisch, D. K., & Pasnau, R. O. (1978). Psychosocial aspects of mastectomy: I. The woman's perspective. American Journal of Psychiatry, 135, 432-436.

Janis, I. L. (1958) Psychological stress: Psychoanalytic and behavioral studies of surgical patients. New York: Wiley.

Jobin, J. (1977, November 15). How men respond to mastectomy. Women's Day, 70-76.

Kaplan, A. (1964). The conduct of inquiry. Scranton, PA. Chandler.

Kaplan, H. S. (1974). The new sex therapy. New York: Brunner Mazel.

Kirkley-Best, E., & Kellner, K. (1982). The forgotten grief: A review of the psychology of stillbirth. American Journal of Orthopsychiatry, 52(3), 420-430.

Klein, R. A. (1971). A crisis to grow on. Cancer, 28, 1660-1665.

Kriss, R. T. (1982). *Effectiveness of group therapy for problems of post-mastectomy self-perception, body image, and sexuality*. Unpublished doctoral dissertation, California Graduate School of Marriage and Family Therapy, San Rafael, CA.

Lazarus, R. (1961). *Patterns of adjustment and human effectiveness*. New York: McGraw-Hill.

Lazarus, R. (1963). *Personality and adjustment*. Englewood Cliffs, Prentice-Hall.

Lazarus, R. (1966). *Psychological stress and the coping process*. New York: McGraw-Hill.

Lazarus, R., Averill, J., & Opton, E., Jr. (1974). The psychology of coping: Issues of research and assessment. In G. Coelho, D. Hamburg, & J. Adams (Eds.), *Coping and adaptation* (pp. 249-315). New York: Basic Books.

Lazarus, R., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer.

Lazarus, R., & Launier, R. (1978). Stress-related transactions between person and environment. In L. Pervin & M. Lewis (Eds.), *Perspectives in interactional psychology* (pp. 287-327). New York: Plenum.

Lee, E. C., & Maguire, G. P. (1975). Emotional distress in patients attending a breast clinic. *British Journal of Surgery*, *62*, 162.

Leo, J. (1978, March 6). Mirror, mirror on the wall. *Time*, p. 54.

Levinson, D. (1978). *Seasons of a man's life*. New York: Alfred A. Knopf.

Lewison, E. (1981). Current concepts. In E. Lewison & A. Montague (Eds.), *Diagnosis and treatment of breast cancer* (pp. 1-16). Baltimore: Williams & Wilkins.

Lindemann, E. (1965). Symptomatology and management of acute grief. In H. Parad (Ed.), *Crisis intervention: Selected readings* (pp. 7-21). New York: Family Service Association of America.

Madge, J. (1965). *The tools of social science*. New York: Doubleday Anchor.

Maguire, P. (1978). The psychiatric problems after mastectomy. In P. C. Brand & P. A. Van Keep (Eds.), *Breast cancer: Psychosocial aspects of early detection and treatment*. Baltimore: University Park Press.

Marris, P. (1975). *Loss and change*. New York: Anchor Books.

May, H. J. (1981). Integration of sexual counseling and family therapy with surgical treatment of breast cancer. *Family Relations*, *30*(2), 291-295.

McCauley, C. (1979). *Surviving breast cancer*. New York: E. P. Dutton.

Mead, M. (1949). *Male and female: A study of the sexes in a changing world*. New York: William Morrow.

Mechanic, D. (1974). Social structure and personal adaptation: Some neglected dimensions. In G. Coelho, D. Hamburg, & J. Adams (Eds.), *Coping and adaptation* (pp. 32-44). New York: Basic Books.

Menninger, K. (1963). *The vital balance: The life process in mental health and illness*. New York: Viking.

Metze, E. (1978). Couples and mastectomy. In P. C. Brand & P. A. Van Keep (Eds.), *Breast cancer: Psychosocial aspects of early detection and treatment* (pp. 25-32). Baltimore: University Park Press.

Millhone, M. (1980). *An application of object relations theory to understanding the mourning process*. Unpublished doctoral dissertation, California Institute for Clinical Social Work, Berkeley, CA.

Monat, A., & Lazarus, R. S. (1977). *Stress and coping: An anthology*. New York: Colombia University Press.

Morris, T., Greer, H. S., & White, P. (1977). Psychological and social adjustment to mastectomy: A two-year follow-up study. *Cancer*, *40*, 2381-2387.

Moustakas, C. (1967). Heuristic research. In J. F. T. Bugental (Ed.), *Challenge of humanistic psychology* (pp. 101-107). New York: McGraw-Hill.

Murphy, L. B., & Moriarty, A. E. (1976). *Vulnerability, coping, and growth: From infancy to adolescence*. New Haven: Yale University Press.

Nichols, W. G. (1978). *Spouse attitude toward mastectomy*. Unpublished master's thesis, California State University, Sacramento.

Oles, E. (1982). *Spouses of cardiac patients: A descriptive study of self-help support group for wives of cardiac patients*. Unpublished doctoral dissertation, California Institute of Clinical Social Work, Berkeley, CA.

Peack, A. (1972). Emotional reactions to having cancer. *American Journal of Reentogenology*, *114*, 591-599.

Pearlin, L. & Schooler, C. (1978). The structure of coping. *The Journal of Health and Social Behavior*, *19*, 2-21.

Polkinghorne, D. (1983). *Methodology for the human sciences*. Albany, New York: State University of New York Press.

Quint, J. C. (1963). The impact of mastectomy. *American Journal of Nursing*, *63*(11), 88-92.

Renneker, R., & Cutler, M. (1952). Psychological problems of adjustment to cancer of the breast. *Journal of the American Medical Association*, *148*, 833-838.

Rinker, E. (1982). *A group design for mastectomy women*. Unpublished master's thesis, California State University, Sacramento.

Rollin, B. (1977). *First you cry*. New York: J. R. Lippincott.

Schain, W. S. (1981). Self-esteem, sexuality, and cancer management. In J. Goldberg (Ed.), *Psychotherapeutic treatment of cancer patients* (pp. 316-336). New York: Free Press.

Schoenberg, B., & Carr, A. C. (1970). Loss of external organs: Limb amputation, mastectomy, and disfigurement. *Loss and grief: Psychological management in medical practice*. New York: Columbia University Press, 119-130.

Selltiz, C., Wrightsman, L., & Cook, S. (1976). *Research methods in social relations*. (3rd ed.). New York: Holt, Rinehart, and Winston.

Shands, H. C., Finesinger, J. E., Cobb, S., & Abrams, R. D. (1951). Psychological mechanisms in patients with cancer. *Cancer*, *4*, 1159-1170.

Sharing the pain of abortion (1983, September 26). *Time*, p. 78.

Sheehy, G. (1976). Passages: Predictable crisis of adult life. New York: E. P. Dutton.

Simos, B. F. (1979). A time to grieve. New York: Family Service Association.

Skelton, M., & Dominian, J. (1973). Psychological stress in wives of patients with myocardial infarction. British Medical Journal, 2, 101-103.

Small, E. (1979). A breast conscious society. In D. Marchant & I. Nyirjesy (Eds.), Breast disease (pp. 1-7). New York: Grune and Stratton.

Snyderman, R. (1978). Reconstruction of the breast. In H. S. Gallagher, H. P. Leis, R. Snyderman, & J. Urban (Eds.), The breast (pp. 333-340). St. Louis: C. V. Mosby.

Sussman, S. (1984). The study of structures. Unpublished manuscript.

Tripodi, T., Fellin, P., & Meyer, H. (1969). The assessment of social research. Itasca, Illinois: F. E. Peacock.

Tripodi, T., & Epstein, I. (1980). Research techniques for clinical social workers. New York: Columbia University Press.

Vaillant, G. (1971). Theoretical hierarchy of adaptive ego mechanisms: a 30 year follow-up of 30 men selected for psychological health. Archives of General Psychiatry, 24, 107-118.

Vaillant, G. (1977). Adaptation to life. Boston: Little, Brown.

Visotsky, H., Hamburg, D., Goss, M., & Lebovitz, B. (1961). Coping behavior under extreme stress. Archives of General Psychiatry, 5, 423-448.

Wabreck, A. J., & Wabreck, C. J. (1976). Mastectomy sexual implications. Primary Care, 3(4), 803-810.

Warner, M. (1976). Alone of all her sex. New York: Vintage Books.

Weisman, A. D., & Worden, J. W. (1975). Psychosocial analysis of cancer deaths. Omega: Journal of Death and Dying, 6, 61-75.

Weiss, E. (1975). The female breast. New York: Bantam.

Wellisch, D. K., Jamison, K. R., & Pasnau, R. O. (1978). Psychosocial aspects of mastectomy: II. The man's perspective. American Journal of Psychiatry, 135, 543-546.

White, R. (1974). Strategies of adaptation: An attempt at systemic description. In G. Coelho, D. Hamburg, & J. Adams (Eds.), Coping and adaptation (pp. 47-68). New York: Basic Books.

Wilson, R. A. (1974). The book of the breast. Chicago: Playboy Press.

Winick, L., & Robbins, G. F. (1977). Physical and psychological readjustment after mastectomy. Cancer, 39, 478-486.

Witkin, M. H. (1975). Sex therapy and mastectomy. Journal of Sex and Marital Therapy, 1, 290-304.

Witkin, M. H. (1979). Psychological concerns in sexual rehabilitation and mastectomy. Sexuality and Disability, 2, 54-50.

THEA DISTE WILSON Ph. D. 1986