NIGERIAN JOURNAL OF HEALTH, EDUCATION AND WELFARE OF SPECIAL PEOPLE

Vol. 4 No 1&2 2000

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NIGERIAN JOURNAL OF HEALTH, EDUCATION AND WELFARE OF SPECIAL PEOPLE
VOLUME 4 NO. 1 &2 (2000 EDITION)
(Published March and August each Year)
ISSN: 1118 - 1257

PSYCHOLOGICAL MANAGEMENT OF NEGATIVE THOUGHTS IN WOMEN WHO HAVE HAD MASTECTOMY

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ABSTRACT

The purpose of this study was to explore the effectiveness of cognitive restructuring technique in the control of negative thoughts in breast cancer patients during the grieving process post mastectomy. Thirty breast cancer patients, who met certain specified criteria, were recruited for this study after obtaining their consent, from the radiotherapy out-patient Department of the University College Hospital, Ibadan. A pretest – posttest longitudinal research design was utilized. The subjects received training in cognitive restructuring technique as a coping skill, for a period of 4 weeks to help them adjust to mastectomy. Using Inventory of Negative thoughts, the effect of cognitive restructuring technique was tested on the control of negative thoughts by the patients. The findings revealed that there was a decrease in the occurrence of negative thoughts in the patients at the end of the training sessions. The study confirms that cognitive restructuring technique has a significant role to play in the control of negative thoughts of patients during the grieving process.

INTRODUCTION

Breasts are important symbols in our society of physical beauty, femininity, mothering, nurturance, and desirability. The breast to many women is a symbol of femininity. It is a significant part of their gender, identity and is important to their sex role. It influences their interpersonal communications and represents their capacity to be sexual. Many men and women have been conditioned to believe that femininity and sexual attractiveness are directly related to the size of the breast. From the time adolescent girls first begin to develop breasts, they are preoccupied with how their breasts look; how fast their breasts are changing and what their breasts are like compared with the breast development of their friends.

The serves three functions; it beautifies the body, provides nourishment for the newborn baby and is a secondary sex organ. In the western culture, the breast is considered a significant component of feminine beauty. Shapeliness is a quality much desired and is emphasized in a woman's choice of clothing. Particularly in the United States, the social value placed on looking young has led to consumer demands for brassieres that further contribute to a trim fit look. One only has to observe the way in which breasts are provocatively displayed by the media for promoting products and attracting people's attention. Among Africans, breasts also have an intense cultural significance, and Nigerian women find breast

problems especially most disturbing. A woman's reaction to any actual or suspected disease or injury affecting her breast tend to reflect the prevailing societal view of the female breast. In the course of a woman's life, the breast is prone to some diseases, of which cancer is the most dangerous and mastectomy is the oldest and most common treatment for early breast cancer. because of these reasons, many Nigerian women find breast problems especially disturbing. In the course of a woman's life, the breast is prone to some disease, of which cancer is the most dangerous and mastectomy is the oldest and most common treatment for early breast cancer.

CANCER, MASTECTOMY AND BODY IMAGE

Cancer and cancer treatments are by their very definition destructive (White, 2000). The destructive influence of the disease and /or of the treatment on appearance may involve loss of body part, scarring, disfigurement, or having to adjust to a prosthesis or limitations in functional abilities (Anderson and Johnson, 1994). Substantial number of women report dissatisfaction with mastectomy scars and/or discontentment with prosthesis (Maguire, Brooke, Tait, Thomas and Sellowood, 1983).

Body image is the way a person sees himself or herself in the world. It is that internalized metal picture one has of oneself, derived dynamically and involving personal perceptions of one's body. A person's body image develops over a span of years and has a psychological and physiologic foundation. Body image influences a person's self-concept and self-esteem and has impart on his or her sexual self and in turn, on sexual functioning, sexual roles and sexual relationships (Lion, 1982). It involves emotional investments of varying degrees in parts of the body.

Surgery has a strong impact on the emotional investment because the body changes; therefore when a person suddenly finds himself without the presence or function of a body part, he or she will react emotionally to the trauma or surgery.

After a mastectomy, women may perceive themselves as handicapped and consequently will respond as a handicapped person in areas dealing with their sexuality. These responses spill over into other aspects of living, such as parenting and working roles, and the woman's total self-image can be diminished (Abt, MaGurrin, and Heintz, 1978). Wabrek and Burchell (1979) fell that the woman who has a mastectomy must cope with multiple problems: the possibility of recurring cancer, the way the operation will affect her relationship with significant others, adjusting and relating to a strange body with only one breast, and her own changed sexuality. The meaning she attached to this lost part will play a significant role in her adjustment.

Since grief is a natural response and the subjective state that follows loss, such as the loss of an aspect of self, and considering the psychological importance of breasts in our cultural, women who grieve over the loss of their breast (through mastectomy) should be seen as being normal and treated with empathy. Their concern over breast loss is as appropriate as other person concern over the loss of limbs or other body parts. Thus this paper will highlight

how cognitive restructuring technique was utilized in training breast cancer patients to adjust to the psychological effects of loss of body parts.

THEORETICAL MODEL

This study was based on the theory of cognitive restructuring which is a type of cognitive behavioral models. Cognitive behavioral models are based on the premise that as individuals, we are constantly processing information and that the nature and results of this processing can be used to understand psychological dimensions of human experiences. These models emphasis the importance of understanding ways of interpreting information, and the way this links, with life experiences, emotions and behaviours. Therapies based on these models emphasis the importance of identifying the predominant process, beliefs and thoughts that mediate psychological problems or disorders and on modifying these to facilitate changes in related areas. Clients are trained to monitor what they say to themselves in stress provoking situations, and then to modify their cognition in adaptive ways.

The loss of a breast, with it's accompanying grief, affects a woman's sex role and her sexual relationship. Without the adequate support of nurses, health psychologists, her adaptation becomes more problematic. It is against this background, that the type of psychological intervention used in this study is most desirable and valuable.

RESEARCH QUESTIONS

Some questions this study attempt to answer are:

1. Can cognitive restructuring technique be effective in controlling the occurrence of negative thoughts among women who had mastectomy?
2. Can the control of negative thoughts enhance the quality of life of persons living with breast cancer? And
3. Can the mastery of this psychological techniques by clients assist them better with the stress of coping with mastectomy?

METHODOLOGY

Patients

A consecutive series of recently operated breast cancer patient was recruited from the Lola Marinho Counseling Clinic, UCH Ibadan. Those 30 patients who were physically stable after mastectomy were included provided they were aged 25-60 years, able to read and write, willing to participate in the study through our the training period and judged by the treating clinician to have a good chance of surviving two years or more.

Assessment

Eligible patients were approached for consent. In all, these thirty patients who agreed to participate were met by the investigator who administered a structured questionnaire during the interview process. This consisted of demographic and clinical details developed by the investigator and the Inventory of Negative Thoughts in Response to Pain (INTRP) developed by Gil et al (1990).

Data on the subjects' performance on the INTRP were collected pre-and post treatment.

Instrument

The Inventory of Negative thought in Response of Pain (INTRP) developed by Gil, Williams, Keefe and Beekham (1990) was used to assess the outcome measures. This inventory consists of 24 items with 4 domains on negative self-statements (NSS) negative social thoughts (NSOT), self-blame-thoughts (SBT) and others-blame thoughts (OBT).

Comprehensive approaches to pain management emphasise the importance of modifying maladaptive negative thought patterns in pain patients (Turk, Meichenbaum and Genest, 1983). Clinicians who work in the pain areas, however, realise that patients are often unable to recognise and accurately report their negative thoughts (Gil, Ross & Keefe, 1988; Turk et al, 1983). One way to examine negative thoughts is to assess the degree to which patients' report having negative thoughts during pain experience (Turk et al, 1983).

Clinical observations suggest that negative thoughts may be frequent during flare-up (Gil et al, 1988) Individuals who may be reluctant t admit to having negative thoughts in general; may report negative thoughts during pain experience.

Cognitive response to pain may significantly influence patients' adjustment (Turk et al, 1983). Patients who view pain experiences negatively (e.g as a disastrous occurrence, outside of their control, or as a reflection of personal failure), may become inactive, withdraw from family and social relationships.

The INTRP is a useful instrument for examining negative thinking patterns in cancer patients suffering from pain. The original version of INTRP is a 22-item scale with 3 domains on: negative self statements, negative social cognition; and self-blame thoughts. In this study, a fourth domain on others-blame thoughts, comprising two questions was added to reflect the cultural variation of Nigeria bringing the total item to 24. Studies have found that the INTRP is a reliable and valid instrument that is sensitive to clinical improvement following cognitive therapy (Bisno, Thompson, Breckenridge and Gallagher, 11985; Deardorffet, Hopkins and Finch, 1984; Harrell and Ryon, 1983).

Process

A small group of 6-8 persons was constituted at the start of each session or round. Following consenting to the study, group members (maximum of 8 persons in each round) were introduced to the aims and objectives of the training program, which include;

1. To create a forum, consisting of post-mastectomy patients and their caregivers.
2. To teach the women the necessary skills to cope with the stress of living with cancer.
3. To specifically train them in cognitive restructuring technique which will enable them change their mal-cognition.

With this background information, the group agreed to meet on a weekly basis, for duration of 60 minutes, per meeting. The training lasted 4 weeks.

SCRIPT ON COGNITIVE RESTRUCTURING TRAINING
COMMON IRRATIONAL BELIEFS*

1. I must be loved and approved of by every significant person.
2. I must be competent and achieving in every area.
3. The world should be a fair place and I should always be treated fairly.
4. When people act badly or unfairly, they are horrible people and deserve to suffer for their sins.
5. When I do something badly, I am a failure/ a hopeless person / a loser, etc.
6. If there is a chance that something bad might happen, I should keep thinking about it.
7. The world should provide me with what I need. Life should be easy and comfortable. I shouldn't have to suffer or feel pain.
8. When things go wrong, it's terrible and catastrophic.
9. Human unhappiness is caused by life's circumstances. The way we feel is determined by the things that happen in our lives.
10. It's better to avoid taking risks or confronting problems. That way we can avoid pain or hassles.

**Adapted from Reason and Emotion in Psychotherapy Albert Ellis, Wiltshire Book Co. California, 1975.*

COMMON IRRATIONAL BELIEFS THAT CREATE DISTRESS AMONGST CANCER PATIENTS

(i) I should always be healthy and have lots of energy
(ii) I should never be needy or dependent on others
(iii) I should be in full control over the things that happen in my life
(iv) I should be "sexy" and have high libido
(v) I should always be positive.
(vi) I should be productive and get lots of thing done
(vii) I should never put my own needs first
(viii) I should have two breasts
(ix) I should endure pain or hardship without complaining
(x) I should be working
(xi) I should always be happy, bright and cheerful.
(xii) I should never say or do things that might make people feel uncomfortable.
(xiii) I should always look good
(xiv) I should be able to foresee all possible problems and prevent them from happening.
(xv) People should be sensitive to my needs and always support me
(xvi) Doctors should be able to prevent my cancer from spreading.

THOUGHT MONITORING EXERCISE

SITUATION/FEELINGS	THOUGHTS	BELIEFS	DISPUTE
Had to cancel family outing-guilt	I, m letting them down. They must be sick of me being so unreliable	I should never cancel engagements. If I cancel, they will think less of me, and won't include me in future outings.	I am usually reliable. It's ok to cancel if I'm not feeling well. They don't judge me so harshly. They know I have cancer. They'll understand.
Looked in the mirror – didn't like what I saw - despair	I look dreadful I've aged 20 years in the last 12 months I'll have to keep out of sight for the moment	I should always look good. People shouldn't see me when I look like this	I don't look great at the moment, but that's the effect of chemo. I'll look better when my hair grows back, and when I'm feeling better it's ok to look lousy at times
Family members don't help with the cleaning -anger	Why is it always up to me? Why can't they think of helping?	They should have the same values and priorities that I do. They should want to help with the house work.	They have the right to their priorities. I wish they were more interested in helping, but they're not. I'll have to clearly communicate that I need their support.

SOME COPING STATEMENTS FOR MANAGING ANXIETY

- *Relax!*
- *Whatever happens, I'll cope.*
- *I live fully today – one day at a time*
- *Calm, peaceful and still. – I let go and relax*
- *There is nothing to fear*
- *I can cope with whatever comes my way*
- *One day at a time]*
- *Whatever the future brings*
- *I'll deal with it – if and when I need to*
- *The pain of my fear*
- *Is always greater]*
- *Than the object of my fear*
- *Relax into the world*
- *Accept that there are come things you can't control*
- *If you can't change it, then let it go!*
- *Breathing in I calm my body,,*
- *Breathing out, I smile.*
- *My mind is a haven of peace and tranquillity*

ACCEPTANCE

THIS IS HOW IT IS
NOT HOW IT
Was
– Might have been
– Should have been
–

NOT HOW
- I wanted it to be
- Hoped it would be
- Planned it would be

I ACCEPT THAT THIS IS HOW IT IS

Now I'll get on with my life in a positive way.

GOALS SETTING SHEET
Relationship:
Leisure/Interests:
Self-development:
Health:
Spiritual:

CONTRACT

I, Mrs. K.O. make a commitment to work towards the following goal:
Make two new friends
In order to achieve my goal, I will take the following steps:

- Join BreCan Support Group
- Call Peju and Tayo – suggest a dinner outing for Friday night
- Make an effort to initiate social engagement – don't always wait for others to call me
- Be more self-disclosing with people at work.

The first step is: arrange dinner with Peju and Tayo which I will do on: Tuesday. I expect to have achieved my goal by December 1998.

When I achieve my goal, I will benefit by:
- having more people in my life – which is more satisfying;
- feeling better about myself – know that I can make new friends; and
- go out more-have more fun.

DATA ANALYSIS

Simple descriptive statistic such as mean, standard deviation, frequency and percentages were used to analyze the variables under study.

RESULT

The descriptive finding in relation to the demographic and clinical variables are displayed in Tables 1 & 2.

TABLE 1: DEMOGRAPHIC VARIABLES OF SUBJECTS

VARIABLES	FREQUENCY	PERCENTAGE
Age (Years)	No.	%
25-30 years	3	10
31-48 years	22	73.3
49-60 years	5	16.6
Matital Status		
Never Married	2	6.7
Currently Married	25	83.3
Separated	-	-
Widowed	3	10
Religion		
Christianity	20	66.7
Islam	10	33.3
Educational Status		
Primary Education	-	-
JSS/SSS Education	10	33.3
Technical Education	15	50
University Education	5	16.6
Occupation		
Petty Trading	3	10
Professional/Senior Civil Servant	12	40
Business/Self Employed	6	20
Student	-	-
Artisan	7	23.3
Not Employed	2	6.7
Income Per Annum	2	6.7
6,000 – 20,000		
20,000 – 60,000	19	63.3
60,000 – 120,000	6	20

TABLE 2: DESCRIPTIVE STATISTIC FOR THE CLINICAL PRESENTATION BY SUBJECTS.

VARIABLE	FREQUENCY	PERCENTAGE
Stages of Breast Cancer		
State II	10	33.3
State III	15	50
State IV	5	16.6

TABLE 3; MEANS AND STANDARD DEVIATIONS OF THE GROUP (PRE- AND POST-TRAINING).

	INVENTORY		PRE-PROGRAM	POST-PROGRAM
INTRP	NSS	No	2.9	4.4
		SD	.71	.38
	NSOT	No	3.2	4.5
		SD	.93	.37
	SBT	No	3.3	4.6
		SD	.99	.37
	CBT	No	3.3	4.5
		SD	1.5	.72

SUMMARY OF FINDINGS

As evident from Table 3, there was a trend towards a decrease in the occurrence of negative thoughts among the group after the four-week training. The woman were able to use their coping resources to make a successful psychosocial adaptation. Cognitive restructuring was found to be effective in modifying the feelings of anxiety, depression and hostility in these subjects. These findings support Ellis (1962, 1991) and Beck (1976) who argued that an individual's cognition or appraisal of external events profoundly influence their feelings; and that anxiety, depression and hostility can be modified by means of cognitive disputing with conjunction with behaviorual therapy methods. Our results are consistent with the views of Turk, Meichenbaum and Genest (1983), who opined that comprehensive approaches to pain management emphasise the importance of modifying maladaptive negative thought patterns in pain patients, and the meta-analysis of Meyer and Mark (1995) who concluded that psychological interventions have positive effects on emotional adjustments, and treatment disease related symptoms in adult cancer patients.

The patients who participated in this study were able to identity their automatic dysfunctional thoughts and underlying beliefs that allow for a more rational response thus allowing for restructuring or modification of thought process or cognition.

CONCLUSION

The study has confirmed that patients who grieve over loss of body parts such as breasts, could be assisted through the use of cognitive restructuring techniques to improve their self-esteem thus enhancing their overall quality of life. There is need for increased awareness of the importance of psychosocial factors

among care givers in oncology settings, that could affect the outcome of patient's response to treatment. Health professionals need to provide post-mastectomy counseling services to women who had undergone this treatment modality in other to enhance their overall quality of life.

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HEALTH AND SAFETY EDUCATION IN EDUCATION INDUSTRY

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ABSTRACT

Safety education main goal is the integration of safety into people's lives. This paper discussed the place of safety education in educational institutions and made appropriate recommendations.

INTRODUCTION

Every year in Nigeria, more than two thousand school-age children are killed in accidents. What these youngsters might have accomplished as adults will never be known. Perhaps one might have been a Nobel prize winner, like Wole Soyinka, or another might have been president of Nigeria. Moreover, all of them would have been precious and integral part of the lives of their friends, relatives and parents.

Concept of Safety Education

In today's society, children, as well as persons of all ages, do not have to die suddenly and unexpectedly with their potential unfulfilled. Accidents can be prevented, and lives can be saved. This belief is succinctly expressed in the following definition; safety is the prevention of accidents, and the mitigation of personal injury or property damage which may result from accidents.

The instrument by which safety can be accomplished is safety education. Although numerous and diverse definition for safety education are available, the following is suggested for us in this paper: Safety education is the entire range of events experienced by a person during his life time that effectively and favourably influence in him the development of certain emotions, attitudes, personality traits, habits, knowledge, and physical skills which are necessary for his safe behaviour in specific environments including school or education industry.

According to this definition, safety education has at least five distinct components. First, any of the events which are experienced by a person during his life time may contribute to his safety. Thus, safety education, which begins at birth and continues throughout the person's life, may originate from any number of different sources.

Second, not all of the apparent safety-producing events experienced by a person are effective in developing safety. Consequently, while a person may have