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Factors and Coping Styles Related to Breast Cancer Patients' Preferences About Referrals to Psychotherapy as part of Treatment

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ABSTRACT

Background: The purpose of this mixed methods study was to examine what factors may influence emotional suppression and expression in breast cancer patients and how coping styles relate to beliefs about physician-driven referrals to therapy.

Methods: A mixed method research design was used consisting of quantitative methods including a demographics survey, the Courtald Emotional Control Scale and treatment preference questionnaires followed by optional participation in a semi-structured interview.

Results: Demographic variables including age, marital status, income, and experience of psychotherapy prior to breast cancer diagnosis are statically significant factors that influence CECS scores and coping styles. Participants universally believed that there should be some level of psychotherapy referrals for supportive mental health care during and after the treatment process.

Conclusion: Participants who fell into either category of emotional suppressor or emotional expresser believed that there should be physician driven referrals to therapy during the breast cancer treatment process. Both those identified as suppressors and expressers indicated high rates of concealing one's true emotional experience. This highlights the need for psychological therapy referrals to be integrated as a best practice, regardless of patient's identified coping style or demographic identities. We suggest that all breast cancer patients be screened at multiple points and offered a referral by every member of their treatment team regardless of how they seem to cope. We also suggest that future research focus on the most efficient and holistic ways to decrease barriers to receiving psychological support during and after breast cancer treatment.

INTRODUCTION

A breast cancer diagnosis is the first in a multitude of complex, emotionally challenging moments that accompany the journey of living with a life-threatening illness. Much of the literature covers the emotional impact of a breast cancer diagnosis[1,2], including Mitchell *et al.*[3] who demonstrated many people living with breast cancer experience higher rates of depression and anxiety compared to the general population and Spiegel & Riba[4] who found a variety of negative psychological impacts on breast cancer patients and their families. However, psychotherapy referrals during diagnosis, treatment and post-treatment of breast cancer remain under-researched.

Nearly 25% to 50% of those diagnosed experience at least one significant episode of anxiety or depression, and in the year post-diagnosis, women demonstrate nearly twice the rate of anxiety,

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depression or both as compared to the general population.[5] A number of studies have shown that psychotherapy has been effective in improving well-being in breast cancer patients[6], treating anxiety, depression[7] and PTSD.[8] There is no standardized best practice about referrals to psychotherapy during the diagnosis and treatment process. There is also little discussion of the profile or type of breast cancer patients that might benefit from psychotherapy, such as the emotional coping profiles and/or demographics that might indicate whether the person receives a referral.

There are some recommended assessment tools to measure distress available such as the Distress Thermometer (DT) and the Problem List (PL).[4,9] Both the DT and PL require the patient to be: a) aware of what they are feeling, b) honest with themselves about how they are feeling and coping and c) require self-disclosure for assessment. Those unwilling to express to themselves or others their distress[10] are known to have 'Type C' coping strategies or emotional suppressors. These individuals *appear* fine, present as friendly, helpful, perfectionistic, self-sacrificial, cooperative, outgoing, warm, non-argumentative, and suppress their own needs in favor of others, while they are secretly unable to cope with these cancer-related stressors. Poorer coping styles have been found to lead to poorer overall treatment outcomes, quality of life and even higher rates of mortality.[11] When Type C copers are faced with *extreme* stress such as a breast cancer diagnosis, their coping skills are ineffective[12-14] and may either: a) continue with Type C coping, resulting in worse emotional outcome, b) develop hopelessness and learned helplessness, also resulting in worse emotional outcome, or c) develop more adequate coping styles through psycho-intervention, leading to emotional expression, social support, and better outcomes. Current gaps in the literature demonstrates a need for comprehensive assessment of distress in breast cancer patients, a greater understanding of coping, and improving access to referrals and psychotherapeutic intervention. The research question that framed this study concerns the demographic factors that may impact women coping with a breast cancer diagnosis and whether these coping styles relate to patient beliefs about being referred to psychotherapy by their physician.

This mixed methods study examined demographic factors that may impact coping in women diagnosed and being treated for breast cancer and explored if coping styles related to participants' beliefs about physician-driven psychotherapy referrals during the breast cancer treatment process. A mixed methods design is typically chosen when the research team wants a better understanding and a fuller picture of a particular phenomenon.[15]This method was chosen in order to understand if demographic factors and a formalized score that reflects the levels of emotional control related to the beliefs breast cancer patients reported about referrals to psychotherapy. Through the use of the Courtald Emotional Control Scale (CECS), an instrument which categorizes respondents into emotional suppressors versus emotional expressers, we hypothesized that the two groups would have divergent preferences related to whether psychotherapy referrals should be recommended to every newly diagnosed patient. We also hypothesized that emotional suppressors were more likely to report distress concealment during treatment and avoid psychotherapy referrals. There was a specific focus on physician-driven referrals to psychotherapy since the oncologist is often the first and primary information provider and the overall creator of an initial breast cancer treatment plan.

METHODS

Study design

A sequential mixed method research design consisting of quantitative methods followed by qualitative methods was employed in this study. This mixed methods methodology was selected in order for the qualitative information to illustrate findings related to demographics, CECS scores and to add depth to the numbers by highlighting the participant's voices in a way that could not be captured through the CECS scoring and demographics data alone.[16]

Sampling

This study used availability, and purposive sampling methods to recruit women who specifically met inclusion criteria. The participants were 21 years old or older and formally diagnosed with breast cancer in alignment with the study's aim to capture the perspective of breast cancer patients (those receiving treatment currently or in the past) while purposefully excluding the experience of prophylactic surgeries/treatments due to a known hereditary disposition without diagnosis because these women are not considered breast cancer patients, but exclusively 'at-risk' for a cancer diagnosis. Participants were recruited both digitally through approved breast cancer social media pages and outreach at a hospital-based breast cancer treatment center. Sixty-nine women who met the inclusion criteria were selected as the sample and 27 women agreed to participate in semi-structured interviews, to the point at which thematic saturation was reached.[17] Sample size was gathered based on the guidelines outlined in Teddlie and Yu's[18] work on mixed methods sampling in which purposive sampling of thematic saturation in qualitative interviews led to the conclusion of gathering the quantitative data sample.

Data collection and instruments

In the quantitative phase, participants completed a demographics sheet, and the Courtald Emotional Control Scale (CECS).

The Courtald Emotional Control Scale

The Courtald Emotional Control Scale (CECS) (Appendix A) studies emotional suppression and expression in breast cancer patients. It is the most frequently used tool to explore emotional regulation during breast cancer[19], measuring the ability to control or suppress anger, depression, and anxiety. Watson and Greer (1983)[20] reported strong concurrent validity, reliability and face validity for the scale. High scores indicate greater emotional control/suppression, whereas lower scores are indicative of emotional expression. Emotional suppressors tend to have a more fatalistic attitude toward cancer while those who restrained their anger and anxiety felt more hopeless.[14,21] The CECS also outlines the characteristics of patients with Type C coping strategies.

The CECS consists of 21 items that include Likert-type responses ranging from 0 (not at all) to 4 (very much so). Factor analysis through principal component analysis [PCA] verified sampling adequacy (Kaiser-Meyer-Olkin scores =.855), appropriate correlations between items (Bartlett's test, $P<.001$), and adequate correlations between items and three levels in rotated component matrix. In this study, the CECS showed high internal consistency for all three emotions (Cronbach's α = .935): Cronbach's alphas for each emotion were .905 (anger), .914 (depression), and .935 (anxiety), respectively.

Data analysis

Participants were divided into emotionally suppressive or emotionally expressive groups by the median CECS total scores (52.5 with IQR=17),[22] based on the recommendations of Nakatani *et al.* (2014) who were the first research team to divide CECS respondents into two categories. Those above the median were categorized as suppressors and those below were categorized as expressers. Of 69 participants, 46 (66.7%) fell into the Emotionally Suppressive group and 23 (33.4%) were in the Emotionally Expressive group. Chi-square tests were then performed to examine the associations between the two groups (dependent variables) by sample characteristics in SPSS 28.0. Independent samples t-test were conducted to examine the factors influencing CECS scores, followed by paired samples t-tests to explore the changes of emotional distress before and after the cancer treatment. We then conducted two-tailed tests at $P<0.05$.

Mixed methods and qualitative analysis

All 69 breast cancer patients who participated in Phase I were offered the opportunity to participate in a semi-structured interview (Appendix B) to further expand upon their beliefs related to physician-driven psychotherapy referrals. Thirty-nine percent (27 out of 6) of Phase I participants were categorized into Phase II; thirty-seven percent (17 out of 46 of the Suppressor group) and forty-three percent (10 out of 23) of the Expresser group.

Each interview was hand-transcribed by the interviewer to allow for complete immersion in the data and to engage in memoing while coding.[23] Thematic narrative analysis (TNA), which is a strategy of narrative inquiry, provided the analytic framework for this phase. TNA allows for the emphasis to be "on the 'told' - the events and cognitions to which language refers during which "a biographical account emerges from the 'self of the narrator rather than in conversation between a teller and particular listener."[24] Information was kept sequentially in order to "inductively generate a set of stable concepts that is case-centered"[24] as the analytic process keeps the 'story' of the participant intact. After initial transcription, each researcher analyzed each interview separately and engaged in the six-step thematic narrative analysis process. It is important to note one member of the research team had the identity of a breast cancer treatment survivor and one did not. Then, each interview was coded first in a long-block text, and then in a short phrase. After two coding rounds, each researcher independently generated the first round of themes and then met to review and confirm the themes. There were not any significant discrepancies in theme creation between research team members. In the third and final phase of the analysis, cross-case analysis was used to confirm common themes that related to coping with breast cancer. In order to maintain auditability, notes were carefully documented so that others were able to follow the analytic steps. Participants were offered the opportunity to read and revise their interviews.

RESULTS

Participants

Table 1 displays the descriptive participant characteristics. About 90 % of participants (n=61) were between 30 and 59 years old at the time of interview. Nearly 9 out of 10 participants (n=61) were White or Caucasian and about 80% of participants (n=54) were married or lived with partners. Over half of participants (n=35) earned more than $90,000 per year at the time of treatment. One out of three participants (n=26) had attended therapy prior to diagnosis and for those who participated in the semi-structured interview, approximately 30% of the participants (n=20) were in psychotherapy at the time of the interview.

Table 2 confirms that age, marital status, income, and experience of psychotherapy prior to breast cancer diagnosis are statically significant factors influencing CECS scores. Participants at the age of 40 or above, those with no partner, and/or those earning less than $90,000 annual income were more likely to suppress their emotions than those who were younger than 40 years (P=.010), had partners (P=.016), and/or those earning $90,000 or more (P=.012) respectively.

Participants that participated in psychotherapy before their breast cancer diagnosis tended to have lower CECS scores compared to those who had not (P=.012).

Table 3 shows that age and experience of psychotherapy before diagnosis are significant factors explaining the differences between the two groups: suppressors and expressers. Participants in the Expresser group are younger than those in the Suppressor group (P=.015) and are more likely to have participated in psychotherapy before the diagnosis (56.5%) compared to Suppressors (28.3%) (P=.022). Only 26 participants (37.7%) attended therapy prior to diagnosis and 43 participants (62.3%) had no therapy prior to diagnosis. Of the 46 participants who were considered to be Emotional Suppressors, 13 participants (28.3%) attended prior therapy; of 23 Emotional Expressers, 13 participants (56.5%) attended prior therapy.

Additional analysis revealed that one hundred percent of survey participants that attended prior therapy (n=26; 13 expressers and 13 suppressors) held beliefs that psychotherapy helped them make it through their physical breast cancer treatments. Yet, 3 participants (11.5%) of those who had attended therapy before did not believe that physician driven referrals to psychotherapy would be beneficial for them.

Also, 36 participants (83.7%) of all participants that did not attend prior psychotherapy believed that psychotherapy helpful or would have been helpful in coping with their physical treatments. In total, only 5 (7.2%) of all 69 participants felt there was no benefit in psychotherapy referrals or treatment, and none had any prior psychotherapy experience.

Interviews revealed the participants' opinions on implementing standards of care for psychotherapy referrals for all breast cancer patients (n=69). Thirty-seven percent (n= 17) of the Suppressor group and 43 percent (n=10) of the Expresser group who participated in the semi-structured interview and one hundred percent of all participants in Phase II, regardless of their coping style, believed that their oncologist or other providers should refer each newly diagnosed patient to psychotherapy.

Table 1 Descriptive statistics of participants

Values	Freq (valid %), (n=69)
Age (Years)	
21-29	4 (5.8%)
30-39	24 (34.8%)
40-49	24 (34.8%)
50-59	13 (18.8%)
60 or older	4 (5.8%)
Ethnicity	
White or Caucasian	61 (88.4%)
Black or African American	4 (5.8%)
Hispanic or Latino or Others	4 (5.8%)
Marital Status	
Married or domestic partner	54 (78.3%)
Divorced or separated	11 (15.9%)
Single or never married	4 (5.8%)
Income ($)	
10k-29k	3 (4.3%)
30k-49k	9 (13.0%)
50k-69k	10 (14.5%)
70k-89k	5 (7.2%)
90k-149k	19 (27.5%)
150k or more	16 (23.2%)
Time after diagnosis	
Still treatment	15 (21.7%)
Less than one year	5 (7.2%)
1-4 years	29 (42.0%)
More than 4 years	20 (28.9%)
Health status	
Currently in treatment	20 (28.9%)
No Evidence of Disease (NED)	47 (68.1%)
Therapy before diagnosis	
Yes	26 (37.7%)
No	43 (62.3%)
Genetic mutation	
Yes	14 (20.3%)
No	54 (78.2%)

One stated:

> I think physician driven referral is obviously the better…I think mental health is definitely under-rated…I think absolutely they should say, 'we have counselors and let's go ahead and set up an initial appointment. Like, not even if you need one, but 'hey, why don't you meet the counselor'? [P15, Expresser]

Table 2. CECS Scores by demographic factors

	Mean (SD)	
Values	CECS Scores (n=69)	T-test scores (P-value)
Age		
21-39 years	53.00 (11.14)	2.37 (.010)*
40 years or older than 40 years	60.17 (13.08)	
Marital Status		
Married or domestic partner	55.54 (12.22)	2.19 (.016)*
Divorced or separated or single	63.47 (13.10)	
Income		
Less than $90,000	61.48 (12.55)	2.33 (.012)*
$90,000 or higher	53.89 (12.92)	
Time after diagnosis		
Still in treatment & less than one year	55.25 (12.19)	.84 (.203)
one or more than one year	58.08 (13.01)	
Health status		
Currently in treatment	58.30 (12.59)	.35 (.365)
No Evidence of Disease (NED)	57.11 (12.98)	
Therapy before diagnosis		
Yes	52.85 (10.88)	2.31 (.012)*
No	59.93 (13.17)	
Genetic mutation		
Yes	58.07 (12.87)	.22 (.412)
No	57.20 (12.90)	

*P<.05 ,**P<.01, ***P<.001

Similarly, another participant talked about the importance of normalizing therapy into a treatment plan:

> I think the doctors need to put it out there saying that it exists. They just…you need to say that this exists and it's a normal thing. Just like…okay, "I'm going to refer you to a plastic surgeon. I'm going to refer you to a counselor." And it SHOULD be part of your treatment plan, rather than not being in there at all and leaving you to figure it out on your own. [P 11, Suppressor].

The Elsa Effect

Content analysis revealed a strong theme related to Type C coping. Seventy-four percent of all Phase II participants (82% suppressors and 60% expressers) indicated trying to conceal their true emotions. This is noteworthy that even those characterized as expressers acknowledged actively hiding their feelings.

One suppressor stated:

> I'd work all day and try not to let anybody know anything was happening. A couple of people had said to me, "Are you okay? You're not really acting like yourself." And I'm like, "I just have a lot of stuff going on. [Suppressor]

An expresser stated:

> My dad…when we broke the news to him, I had to make sure my sister and my brother were with me because he gets very emotional and can't handle these things. So, I had to be the strong one and say, "I'm gonna be fine; I'm going to be okay." And deep down inside, I'm thinking, "I better be." [Expresser]

This level of hiding feelings was an unexpected finding as participants were not asked directly about Type C coping or about concealing one's emotions.

DISCUSSION

Our findings indicate that there are a multitude of factors that may influence whether someone can be categorized in the Emotional Expresser or Emotional Suppressor coping category including age, marital status, income, and experience of psychotherapy prior to breast cancer diagnosis. Rather than focusing on coping style, our findings suggest that oncology treatment teams could use these demographic categories as guidelines to identify those who would benefit from psychotherapy during and after breast cancer treatment, although some form of the CECS could be administered as part of the comprehensive assessment process, especially to flag those at greatest risk of emotional concealment.

Overwhelmingly, most participants, Suppressor and Expresser, felt that a professionally driven referral to psychotherapy can facilitate coping with the emotional and physical impacts of treatment. Interestingly, participants who had prior psychotherapy experience were not the only ones who held beliefs on the psychotherapy benefits following diagnosis.

Table 3. Bivariate statistics between types of expression and covariates

	Freq. (valid %) / Mean (SD)		Test score (*p*-value)
	Expressers (n=23)	Suppressors (n=46)	
Age			
21-39 years	14 (60.9%)	14 (30.4%)	5.89(.015)*
40 years or older	9 (39.1%)	32 (69.6%)	
Income			
Under $90,000	7 (33.3%)	20 (48.8%)	1.35(.246)
$90,000 or higher	14 (66.7%)	21 (51.2%)	
Marital Status			
Married or Domestic partnership	19 (82.6%)	35 (76.1%)	.38(.536)
Divorced, Separated, Single, and Never married	4 (17.4%)	11 (23.9%)	
Time after Diagnosis			
Still in treatment & less than 1 year	9 (39.1%)	11 (23.9%)	1.73(.189)
1 or more years	14 (60.9%)	35 (76.1%)	
Health Status			
Currently in treatment	8 (36.4%)	12 (26.7%)	.66(.415)
No Evidence of Disease	14 (63.6%)	33 (73.3%)	
Therapy before diagnosis			
No	10 (43.5%)	33 (71.7%)	5.22(.022)*
Yes	13 (56.5%)	13 (28.3%)	
Genetic mutation			
No	16 (72.7%)	38 (82.6%)	.89(.346)
Yes	6 (27.3%)	8 (17.4%)	
Distress Score at the Begging (EMOT_B)	9.04 (1.15)	8.43 (1.87)	1.668(.050)*
Distress Score at the End (EMOT_E)	6.33 (2.28)	6.31 (2.07)	.038(.485)

*P<.05, **P<.01, ***P<.001

Additionally, those with a prior psychotherapy history and the majority of those who had not attended psychotherapy before held similar beliefs about the helpfulness of psychotherapy. Regardless of coping categorization, the majority of Emotional Suppressors and Expressers felt that psychotherapy referrals would have been helpful throughout and post-treatment. This indicates that there might not be one specific patient profile that should receive a screening or referrals. We suggest that all breast cancer patients be screened at multiple points and offered a referral by every member of their treatment team, regardless of how they seem to cope. Surprisingly, the percentages of expresser and suppressor participants who self-selected into interviews were evenly divided, suggesting that one CECS group was not more apt to participate in the interview than another.

Studies specific to the referral process for breast cancer patients to psychotherapy remains somewhat limited which may, in part, have to do with language. The challenging physical and emotional experiences during diagnosis, treatment and post-treatment are often referred to under the umbrella term ‘distress’[25] and the referral process for any behavioral health support service, such as psychotherapy, is often referred to under the umbrella term ‘supportive care’[26] and is not discussed as a stand-alone treatment. Supportive care has many different definitions and typically includes physical, emotional, spiritual and practical care as part of overall cancer treatment,[27] yet it does not always include psychotherapy.

Regardless of Emotional Expresser or Emotional Suppressor category, concealment of one’s feelings appeared in nearly three-fourths of all interview respondents, indicating tendencies towards ‘Type C’ coping and a struggle to find effective coping strategies. This supports the findings of Temoshok (1987)[12] Iwamitsu *et al.*, (2003)[13] and (2005)[14] that Type C copers, when faced with extreme stress experiences, fail to use their previously effective coping skills. As these prior studies also highlight, more research in how to support Type C copers as they navigate the cancer treatment process is warranted.

Many participants spoke of hiding feelings from others and themselves throughout treatment and some spoke of not even recognizing emotional concealment until after treatment conclusion. Thus, an ‘open-door’ policy about psychotherapy referrals should be easily accessible and available at any point after diagnosis for all breast cancer patients, and conversations around psychotherapy should be conducted through a de-stigmatized lens in which psychotherapy participation is normalized. The emotional impact of receiving a cancer diagnosis mimics the impact of a violent crime, thereby often leading to symptoms of post-traumatic stress, although the formal diagnosis of PTSD while undergoing cancer treatment remains controversial.[28]

Although our study did not specifically look at psychotherapy and well-being during breast cancer treatment, our findings support the work of Jamshidifar *et al.* (2015)[6] and findings reported by Cordova *et al.* (2017)[28] who argue that receiving a cancer diagnosis can mimic the impact of a violent incident, with increased rates of depression and anxiety following a breast cancer diagnosis.

Limitations

CECS scores were not gathered at multiple points during and following treatment to create comparison groups. Also, participants were overwhelmingly identified as White and of higher socioeconomic status. Further research with more diverse participant groups would help confirm these findings and highlight experiences of breast cancer patients with historically and socially marginalized identities. Nuanced data collection throughout treatment might identify points where psychotherapy referrals may be most beneficial. Finally, longitudinal studies can examine the long-term emotional impact of breast cancer on survivors, particularly Type C copers.

CONCLUSION

There is not one universal experience of breast cancer. The physical and emotional challenges of breast cancer can have a significant impact on one’s ability to cope during and after treatment. Coping styles, whether expressive or suppressive, are profoundly tested and taxed throughout the cancer treatment process, yet psychological support is not universally offered as part of a holistic treatment plan. Demographic variables can influence whether someone may be categorized as an Emotional Expresser or Emotional Suppressor, but regardless of coping style, participants strongly believed that there should be referrals to psychotherapy by multiple providers during multiple points of treatment. Our findings suggest that oncology teams could use demographic factors as indicators for identifying patients who may benefit from psychotherapy during and after breast cancer treatment. Breast cancer treatment teams should include assessment of coping styles as part of assessment, and should consider multiple barriers to accessing services as part of comprehensive treatment planning. Emotional concealment, regardless of coping strategy, may be a common occurrence during breast cancer treatment.

Implications for practice include the suggestion that psychological support should be part of an all-inclusive, holistic and affirming treatment offered simultaneously during diagnosis and treatment, and should be encouraged by all providers, during diagnosis, treatment and post-treatment. Referrals should include a selection of therapeutic options including telehealth, webinar-style psycho-oncology curriculum and a referral to a number of different therapists from which the patient may choose to work. This work also highlights the need to engage in more psycho-oncology based research, including types of psychotherapeutic services that can be offered to breast cancer patients, the role of physicians referring breast cancer patients to psychotherapeutic support and policies, and programs and procedures that can decrease barriers to receiving therapeutic support services during breast cancer treatment. Significantly, more research related to referral points of psycho-oncological therapeutic support should be conducted to deepen our understanding of the intersection of coping, breast cancer treatment, and the role of emotional suppression and expression so that providers may better connect breast cancer patients to emotional support services during and after the treatment journey.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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ETHICAL CONSIDERATIONS

Prior to engaging in the study, all the participants were informed of anonymity procedures, data protection, and study scope. They were provided with a written copy of informed consent. This study was approved by [blinded for peer review] University Institutional Review Board [reference number #461]. All the data was encoded in an electronic database which was password-protected.

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