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Body Image and Self-image Changes after Surgery. Health Psychology Intervention for Women Recovering from Malignant Breast Tumor

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Modern medicine has brought major technological advancements, which caused the wholistic approach to lose ground, and because of the high patient turnover, establishing a good doctor-patient relationship became more difficult (Kabaa & Sooriakumaran, 2007). Surgery entails considerable passivity for the patient, which can hinder successful recovery in its later stages, as patients are often unable to step out of the helpless patient role. With the exploding advances in technology, the surgical treatment of breast cancer has also changed, with the early radical, mutilating procedures being replaced by modern breast-conserving surgery (Mátrai et al., 2015). Currently, modern breast surgery is characterized by oncoplastic operations and advanced reconstructive procedures, which can lead to better aesthetic results and faster physical recovery. In many cases, however, the psychological recovery is much slower and it is not uncommon that the psychological apparatus is unable to catch up with the drastic and rapid physical changes. The messages conveyed by modern medicine can give the illusion that in a matter of moments, we can easily reorganize ourselves (Foucault, 2000), although this process can become psychologically problematic. After all, changes in body image due to physical and/or mental trauma cannot be processed from one moment to the next. Although a 1993 study (Schag et al., 1993) showed less distress in those breast tumor patients who had better cosmetic outcomes, i.e., after surgery they have undergone plastic surgery too, in a longitudinal study design the data could not be reproduced, there was no difference between the two groups in the long term (Al-Ghazal et al., 1999). The psychological balance after surgery is therefore not only dependent on the surgical procedure, but is also influenced by the patient's expectations, representations of the disease, coping strategies, impairment of body image, and the extent to which the person can accept and reintegrate the new situation into his/her previous life (Broadbent et al., 2004; Csabai & Molnár, 1999).

1. Body Image Changes after Surgery

The rate of negative body image and body dissatisfaction due to physical, intrapsychic and interpersonal processes increases dramatically in patients who have undergone surgery. Numerous studies have documented adverse body image and psychological distress, feelings of disfigurement, and loss of femininity in women who have undergone surgery for breast cancer (Donovan-Kicken & Caughlin, 2011; Fairburn et al., 2018; Falk Dahl et al., 2010; Hopwood et al., 2010).

The success of recovery, as also suggested by research findings, strongly depends on the patient's body image impairment (Grogan & Mechan, 2017). According to Collins and colleagues (2018), poor quality of life after mastectomy was mainly associated with damage to body image and femininity.

Surprisingly, among the women who have recovered from malignant breast tumor, those who also underwent breast reconstruction surgery, had a significantly more negative body image than those who did not undergo plastic surgery. However, other studies imply that patients, who underwent reconstruction surgery after mastectomy, rated their quality of life higher and although their self-esteem had not changed significantly, they felt more attractive, "whole again, that there is no need to feel ashamed of their body", in contrast to those women who did not choose plastic surgery after mastectomy (Tykkä et al., 2002). Another study demonstrated that patients who waited more than a year for reconstructive surgery reported fewer psychological problems than women who received implants within a year (Schain et al., 1985). A detailed analysis of the data reveals that psychological status is roughly similar when the two types of intervention are performed in a single treatment (tumor removal and reconstruction are simultaneous) and when patients wait for longer (more than a year) for plastic surgery. Women who had implants within a year were the worst off and had the most psychological problems. A mastectomy seriously disrupts a person's bodily integrity, and it can take up to a year to accept the altered body image (Taylor, 1983). If losing one or even both breasts and the reconstruction happens within a year, it may require such a high level of psychological work that it could overwhelm the psychological apparatus. Both clinical experience and research (Izydorczyk et al., 2018) have shown that patients who have undergone breast cancer surgery should be offered the opportunity to receive professional psychological support as soon as possible, ideally after surgery, when they are less able to deal with negative emotions.

2. Case Study

I have been working with patients with serious physical illnesses requiring surgical care for over ten years. I am always moved by the immense strength I see in them. Fortu-

nately, our profession is getting closer to them, they are becoming increasingly open to psychological help and are interested in the psychological factors that facilitate recovery. Many of them have abandoned the frequently occurring attitude of "I am not mad, why would I need a psychologist", although many times there is still a – justifiable – sense of confusion: "how is this going to help me when I have a tangible, physical illness?" Therefore, the empathy of the healing professionals and their attitude towards recovery are of particular relevance. Dóra's story enables us a look into the difficulties of recovery after breast surgery and the possibilities of health psychological intervention.

Dóra appeared to be a desperate, broken woman. The first time we met, Dóra behaved in a reserved manner, not returning my smile in the waiting room. I walked her into the counseling room. She sat down before looking around, and said, matter-of-factly: *"I have cancer and I think I'm depressed",* then went on to give a lengthy, detailed history of her illness, from the appearance of first symptoms (breast defluxion), getting a diagnosis (precancerous cells were found), waiting for surgery: all without any self-reference or expressing emotions. Her left breast was removed over a year and after a couple of months, she received an implant. The aesthetic correction of the other breast is due in the coming weeks. Dóra was visibly locked into her disease, and as a result I had to work for the two of us for a a period of time.

Holding a university degree, she worked in a top position in the financial sector. She used to love her work, but after the diagnosis, she has found joy in it no longer. As it turned out later, she experienced a great amount of stress and anxiety because of her workplace and deadlines. She is approaching forty, lives with her husband and their two boys. She plans a lot of activities with her family because she feels that being distracted helps. She used to love reading, gardening, baking, and any activity that allowed her to be alone (or rather, by herself). *"I would still love to, but I do not have the time."* The quality of her sleep is particularly poor, she wakes up at dawn and can't go back to sleep. She does see some connection between events in her life and her symptoms, but when I ask her what would be her goal, she mentions stress management and *"being more decisive, I don't really know".* Inevitably a smile appeared on my face, which Dóra returned with a laugh. I felt confident about establishing a good therapeutic relationship. We contracted for 15 sessions, with the aim of working with the disease, recovery, and related factors. During the first sessions, we took the PRISM-D nonverbal drawing test developed and validated by our research team (Sándor et al., 2020), which could also help us to detect the impact of the disease and potential resources. Now I would refrain from presenting the test, but perhaps the blinding whiteness of Dóra's drawing test is still striking (Figure 1). She has left much of the life-area empty, but the disease (red circle) occupies a central place, almost enveloping the self (yellow circle).

She sees her husband and their marriage realistically. There are disagreements (mainly over the household), but they soon get over them. Dóra is slow to open up, talking

shyly about the relationship difficulties caused by the illness and treatments. Her body image has never been very positive, but the losses and body asymmetry caused by surgical treatments have torn her self-confidence apart even more. She is reluctant to look in the mirror, finds it difficult to touch her own body, and has lost confidence in it: "How can I trust my own body again when it has let me down like this?" Choosing the right therapeutic tool is key to fostering a trusting attitude towards your own body. Projective assessment tools that provide a deeper insight into the patient's emotional world are an excellent way to examine the damage to body image and self-image. In Dóra's case, instead of a classic human drawing, we worked with a pre-printed human figure (in my experience, some clients prefer this over receiving a blank sheet) and asked her to complete the template by drawing herself on it. Dóra's image (with her permission) is shown in Figure 2. As she looked at her drawing, she became increasingly aware of the complete absence of feminine gender features in the picture. Then her relationship to her own femininity and her own body came into focus. Although we did not apply it to Dóra at the time, in many cases the body-image-sculpture test is helpful in facilitating a deeper bodily experience and mitigate the damage to the wholeness of bodily experience (Fehér & Kecskés, 2011).

Dóra's depression appeared to be moderate and she refused any possible help of medication. For a while, she seemed completely resistant, but I tried to stay patient. A dynamic appeared: when she comes, she feels fine for a few days afterward, but the effect is not long-lasting. We were halfway through the agreed therapy sessions and I felt we were marking time when the ice finally broke. Dóra experienced a really bad weekend: *"I was annoyed with my husband, the kids, cooking, work, everything, and I don't know why".* When we took a closer look at the situation, the feelings, the real cause of her annoyance, *"I don't know"* suddenly made sense. She cried. *"The illness, still..."* During the remaining time of the session Dóra framed some difficult questions. *"What is the meaning of illness? Why did it come at that particular time? How was my life then? How did I get here?"* An inner work would begin, which eased the grip of depression week by week and her sleep improved. In the evenings she started to write in her diary, so instead of suppressing the feelings, she tried to write out the distressing, painful memories and physical sensations associated with the illness. We are familiar with Pennebaker's (1997) research on the beneficial physical and psychological effects of writing, and we observed these here as well.

We used several projective techniques to better understand the often unspeakable underlying feelings and thoughts. I asked her to draw a picture of her illness (Figure 3), which she found to be a very difficult task. Remember that at the beginning of our work, Dóra spoke without emotions about the trauma she had suffered, the pain caused by the illness and the treatments. After much contemplation, she took a black marker and drew a cell growth covering the breast. When I asked her what could help the disease go away, she thought some more and then drew a sun *"to be enlightened"*

and a human brain *"to accept it". "It will probably stay with me for the rest of my life... (crying) I'm sick."* she said. What happened next still moves me to this day. For a while, we looked silently either at each other or at the table while Dóra cried. It was an exceptionally intimate moment that banished all uncertainty. This is how Dóra started the first session: "I have cancer and I think I'm depressed" – as if she was telling me that she had to work tomorrow. Now she said, "I am sick." We both felt the real weight of that sentence. The fear and pain became almost tangible, the words and feelings became one and we understood the real cause of the problem. What Dóra is really afraid of is the unpredictable, unknown future. How can we change this? We cannot. The future remains unknown and unpredictable. This is not the answer Dóra was looking for, but what we can change is our attitude to illness. Dóra's doctors are very positive about the future, she has been declared cured, she doesn't need check-ups, her treatments have been completed for a year now, and although she has understood this on a cognitive level, it seems that her psyche has not been able to follow these drastic changes.

During the following sessions, we talked about her relation to the illness (How does she think about her illness now?) and her perception of health (What does health mean to her?) Dóra's body has been the scene of dramatic events, the trauma of the illness has torn her life and her representations of it apart. Although visible to me, it was very difficult to grasp the insecurity and the sense of inner emptiness that Dóra was going through. Yet when she did and faced them with enough courage, the negative feelings suddenly began to diminish. The anxiety caused by the burden of a serious illness eventually triggered a radical personality change. She examined her own role in the development of the disease and took a more active, responsible approach toward her health. This was perhaps the turning point, as one of the fundamental problems in treating patients with cancer is the helplessness and the loss of control. We are responsible for the attitudes we hold when facing our problems – our illness, in this case – which can help us at any stage of the disease, increasing our sense of power and control (Yalom, 2019). Raising awareness of responsibility, however, is not an easy task, the therapist soon stumbles upon an uninvited guest: guilt, the dark shadow of responsibility. Before we dive into the most important insights of existential psychotherapy, let us return to Dóra, who, after realizing her own responsibility, set out on a path to personal fulfillment. She is aware that the disease may recur, but her life is no longer ruled by paralyzing fear. The unconscious vegetative reactions have subsided and the negative experiences caused by the disease have been smoothly integrated into the life story. She feels alive, she is trying to have the best possible relationship with her husband and children, she has started to eat healthier, exercise more, and now she is not going "crazy" about work, because she feels in charge and although she cannot control everything, she is doing what she can to stay healthy and balanced.

3. Discussion

3.1. The Traumatic Loss of Self

We should always pay close attention to the first sentences, as they often predict the success of the therapy. Yet as professionals, we should not allow ourselves to be led down the wrong path, getting stuck in words and phrases, such as a detailed description of the treatment process. Often this is the first step of self-disclosure, when the patient talks about her physical complaints, where at the most impersonal level the client is hardly involved in what she is saying, only talking about external events and other people. Let's be patient, it can be a long process before the patient is able to deal with her own inner experiences in an in-depth and differentiated way, and then to change her behavior based on her insights (Tringer, 2007).

Numerous papers deal with reactions to trauma, but we do not know exactly what conscious or unconscious, explicit or implicit processes facilitate the healing process. We do know that a diagnosis of a serious illness brings about changes in the patient's perception, physical experience, and imagination. The patient may often obsessively return to the past, to the moment when she last experienced intense involvement and deep negative feelings: the events surrounding the diagnosis and the surgery. But without mental flexibility and imagination, there is no hope, no possibility to project a hopeful, optimistic future worth living and fighting for (Stupiggia, 2016).

While telling the history of the illness, the empathy and unconditional acceptance of the psychologist helps to build rapport, but in many cases, giving a detailed story is not always helpful even in a therapeutic context. It does not bring relief, because there is a pain we cannot talk about, and instead, we risk getting traumatized again. Actually/In reality, we have no words to describe what happened, because the presence of trauma takes away the relief of the narrative. Of course, we might come up with some kind of a story to hide behind it, but instead of a coherent narrative of emotional charge and experience, we see reactions at the physical level (Stupiggia, 2016). Therefore, verbal therapy techniques alone will not work, and we can also reach a dead end if the treatment is too focused on the body. For example, relaxation techniques can cause passivity, which can induce the helplessness the patient have experienced during surgical and oncology treatments.

3.2. How Can I Trust My Own Body Again?

Most patients facing a serious physical illness tell us that they experience deep and painful insecurities about their own bodies. Usually, after successfully coping with the illness, in the final phase of recovery, patients anxiously ask the question, “How can I trust my body again?” Frequently, the highly anticipated relief would not arrive even after the patient (physically, according to the doctors) has recovered. At any stage of

coping with the illness, this feeling is a huge challenge for us, health psychologists. How can we help the client to regain or build up a trusting attitude towards their own body? The history of the illness and the life story aside, we also include bodily experiences and communication with the body in the therapeutic work. Our body image, our relationship to our body, is such a deeply personal experience that we cannot express it only verbally. Trauma is much more than an event from the past: it leaves a mark on both the body and the mind. Whether it happened a few days or several decades ago, clients are unable to bridge the gap between the current life situation and the traumatic life event, since only that event which caused them so much pain has meaning for them (Tedeschi & Calhoun, 2004; van der Kolk, 2020). Although it matters a lot if patients are supported in putting into words what has happened to them, this is usually not enough for full recovery, as the body still reacts with the same physical and hormonal responses as if the trauma would happen now, in the present. In facilitating healing, we therefore need to override the body's automatic responses, accept on a physical level that the threat is in the past and then learn to live in the present.

Gentle physical interventions can be suggested, in which we work with bodily sensations to restore a positive attitude towards one's own body. Gradually, attention is directed more and more inwards, towards the inside of the body. The accepting attention to bodily sensations, learning to exist in the present and to focus attention holds a lot of potential (Szondy, 2012). Observing bodily conditions and monitoring breathing alone (without regulation or any action to do so) can lead to the elimination of emotional distress (Perczel-Forintos, 2011). However, in many cases, the damage caused to the body image damage is difficult to grasp, as the feelings and experiences associated with it often dissipate before reaching a conscious level. The body always "knows more" than we do, it both senses and is sensed; it is through my body that I grasp the outside world (Merleau-Ponty, 2006). Body image can become a map of the traumas experienced, if the unity of bodily experience, the wholeness of the body is violated, leading to a fragmented body, a splitting of body parts (Geerardyn & Walleghem 2005). This can lead to the patient not being able to touch the affected body part or the site of the operation (for example, their stoma or the scar on their chest after a mastectomy). Fortunately, we now have non-verbal therapeutic and diagnostic tools that reveal bodily experiences, such as the body image-sculpture test (Fehér & Kecskés, 2011) or projective drawing tests (Machover, 1951; Witkin, 1962), which can be used to assess the degree of self-integrity and self-constancy and help to ensure the success of the healing process. According to our most recent knowledge, the best way to assess illness perception and psychological conflict is to use projective drawing tests (Broadbent et al., 2006), which can also be used to examine self-image and body image, self-energy, coping mechanisms and traumas (Vass, 2011).

That the somatic, bodily representations of memories are projected onto the drawing has been explored by several research groups, as they are not only a reflection of the

psychological state, but also of the success of recovery. In cardiology patients, drawing an injury on the heart was not only associated with increased depression and a more negative attitude towards the disease, but clinical data (sodium levels, BNP = confirmed neurohumoral activation) also correlated with characteristics of the drawing test. And the damage drawn on the heart was a better predictor of the patient's recovery than any other medical indicator (Broadbent et al., 2004; Petrie & Weinman, 2012; Reynolds et al., 2007). Our research with transplant patients has shown that in anxious patients, mental representations of the organ are overemphasized, which on one hand prevents normal intrapsychic integration of the organ, on the other is associated with kidney function values and may predict the success of the transplantation (Látos et al., 2021).

The PRISM-D non-verbal drawing test can also be helpful, not only as a research tool but as an integral part of the intervention (Sándor et al., 2020). In Dóra's drawing test, the disease surrounds, or we could say absorbs, the self. The results of our own study together with the findings of other research groups confirm that the larger the subjective image of the disease, the more pronounced the anxiety associated with the disease (Petrie & Weinman, 2012; Sándor et al., 2020). Using drawing tests, we can develop an innovative technique to obtain a more accurate picture of patients' attitudes and beliefs about illness that are predictive of recovery and survival. Drawings are also more effective than verbal questionnaires in assessing the effectiveness of therapies (Horwitz et al., 2006), therefore in many cases a PRISM-D drawing test is administered again during mid-therapy or later.

3.3. Therapeutic Goals and Possibilities: Coherent Self and Positive Body Image

Psychological support before and after breast surgery, which helps the patient to accept the emerging feelings and the new life situation, can also greatly assist the recovery process (McGregor & Antoni, 2009). With psychological interventions, patient cooperation and satisfaction can also be positively influenced. Patients are more likely to follow the doctor's instructions, take their medication accurately and do not miss follow-up visits, which is confirmed by clinical experience and research (Andersen, 2002; Kahana et al., 2008).

In restoring body image and self-image, besides body awareness, there is a strong emphasis on relational work. In health psychology interventions with patients with serious illnesses, even those requiring surgical intervention, we need to give clients the opportunity to express any negative feelings and concerns they may have about their health and their own body. They may show frustration, anger or envy towards others who are healthy. We also need to give room to future expectations, fears and anxieties about possible changes in social relationships. It is the task of the professional to unconditionally accept the patient's experiences, fostering a coherent self (Rogers, 2008). Over time, the client introjects the attitude of the helper, so that the previously

threatening, negative feelings become acceptable and part of the self. Through the integration of new experiences, the individuals learn to know themself in a more complex way, the body image is reconstructed and the previous structure of the self is modified. Another key factor in recovery is that as health psychologists, we do not ally ourselves with symptomatic behavior, but with the patient's best interests, with the self that is healthy and wishes to heal. If the patient takes an active role in their recovery, changes his or her lifestyle, participates in rehabilitation, follows medical advice, etc., they can regain control of their illness and their life, which can result in more balanced psychological functioning.

Lessons learnt from this case

It is inevitable that when clients are struggling with physical illness, working with the body is present in therapeutic work. Any treatment using nothing but verbal methods is almost certainly bound to fail. It becomes difficult for the patient to experience their self-identity as the mutilated body and the psychological problems it causes are only a distant reminder of the person's former self. The damage to the body, the surgical scar, heals relatively quickly, but the damage to the body image and the trauma caused by the illness heal more slowly. Therefore, a well-designed health psychological intervention is of great importance, to help repair the damage to self-image and body image, reduce existing depression, anxiety, and negative attitudes associated with illness. It may improve the patient's quality of life and change health behavior for the better.

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Figure 1. PRISM-D nonverbal drawing test, the yellow circle represents the Self, the white sheet of paper the client's life-area, where she drew her illness first, then important persons and activities, each represented with a circle.

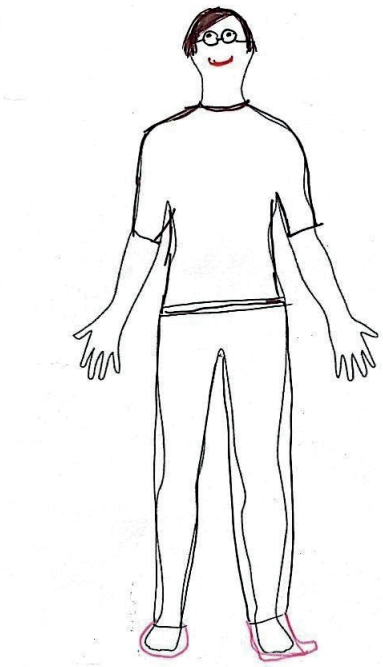

Figure 2. Dóra's own picture of herself.

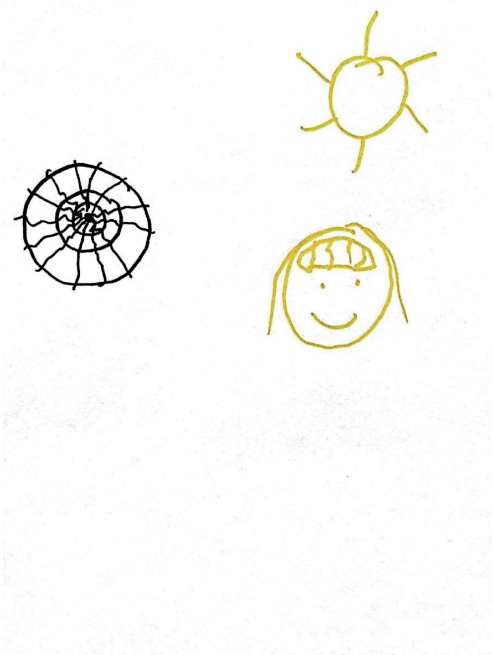

Figure 3. Drawing about the illness and the factors promoting recovery.