

RESEARCH ARTICLE

Self-Disclosure of Breast Cancer Diagnosis by Iranian Women to Friends and Colleagues

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Abstract

Background: Breast cancer (BC) is the most common form of cancer in Iranian women, and it remains a major health problem. An increasing number of young women are being diagnosed with BC, and therefore, there is an increasing likelihood that more women will survive breast cancer for many years. Many opine that self-disclosure of BC diagnosis is important because talking about cancer helps people to make sense of their experiences; in fact, self-disclosure appears to play an important role in many health outcomes. However, this has not yet been studied in BC patients in Iran. Therefore, this study aimed to explore the status of self-disclosure of BC diagnosis by Iranian women to friends and colleagues. **Materials and Methods:** All BC records for 2001-2011 of employed women were studied at five hospitals in Mashhad. Data about the self-disclosure of BC diagnosis were gathered through telephone interviews, and the participants filled out a questionnaire about their status of self-disclosure of BC diagnosis to various groups of people. **Results:** The mean age of employed women at the time of diagnosis was 44.3 ± 6.7 years. Over 60% self-disclosed to work colleagues and over 90% to bosses/managers. Seventy per cent reported that they had support from their family and husband's family, while 95% reported that they had support from parents, siblings, children and friends. **Conclusions:** Most employed women self-disclosed freely to family, friends, colleagues and bosses/managers. Apparently, self-disclosure of breast cancer diagnosis may have negative effects at work. About half of patients reported that they had support from family, managers and colleagues; however, for nearly 28% of employed women, disclosure had less positive effects. In particular, it altered their perception of others, produced difficulties with work and family and diminished closeness with the people who were told. However, the stigma of BC is far less than it once was.

Keywords: Breast cancer - self-disclosure - employed women - Iran

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Introduction

Cancer is the second leading cause of death worldwide, and its global burden has increased more than twofold over the past 30 years (Jemal et al., 2011). Breast cancer (BC) is the most common type, representing 23% of all cancer diagnoses. This is the most fatal form of cancer among women (Harirchi et al., 2011) accounting for 16% of cancer-related deaths (Organization 2011). Therefore, BC remains a major health problem worldwide. Furthermore, it is the most common type of cancer observed in Iranian women (Kolahdoozan et al., 2010). According to statistics from the Iranian Cancer Society, 3,645 new cases of invasive BC were diagnosed in 1998-2002 (Mohagheghi et al., 2009). However, the mortality rates from BC have decreased because more women are now being diagnosed and treated for this disease. A review of women's adjustment to breast cancer suggests that a significant

number of breast cancer patients experience considerable mood disturbances post-diagnosis and surgery (Badr et al., 2010). Moreover, psychological distress may predict the length of survival after cancer diagnosis (Park 2010).

Most women are diagnosed with BC when they are still at an employable age, and a good prognosis assures them a long life expectancy after recovery from the disease (El-Sayed and Ali, 2009). In the past few decades, the survival rate for most cancer patients has steadily increased (Badr et al., 2010). The Diseases factors, as well as individual and work-related factors, considerably influence the chances of returning to work after cancer (Mehnert 2011). Evidence shows that most employed BC survivors are able to return to work (Johnsson et al., 2009; Mehnert 2011; Tamminga et al., 2012); however, they often face difficulties in doing so due to physical or cognitive work limitations (Rozman 2009).

Return to work (RTW) can be considered a type

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of social recovery that enhances the patient's life quality (Wennman-Larsen et al., 2013). The ability of patients with BC to return to work after diagnosis and treatment is an important survivorship issue because it may have consequences related to quality of life and income (McDowell et al., 2010). The impact of support on work outcomes is important in BC survivors, but social support in the context of BC diagnosis may be complicated by potential negative outcomes of disclosure of diagnosis (Frazier et al., 2009).

Fears of being stigmatised and being dismissed from work following discovery of an individual's BC diagnosis are a few reasons why disclosure may not occur. Concealment of breast cancer diagnosis may lead to difficulties in the work environment (Else-Quest et al., 2009).

The majority of women felt that disclosure had a positive effect, including 'more support', 'feeling closer to the people I told', and 'receiving more information and advice from others' (Petersson et al., 2011). However, some felt that it had no effect or negatively changed the way other people perceived them, resulted in insurance problems, made people who were told less close, caused work or job related problems or caused family problems. In addition to the employed women who had negative experiences following disclosure, it is possible that women who chose not to tell certain people may have accurately predicted the potentially negative reaction and sequelae of disclosure on relationships and jobs (Tiete et al., 2010).

Many researchers agree that self-disclosure is important because speaking about cancer helps people to re-evaluate their ideas and perceptions and understand their experiences (Dagan et al., 2013). We use the term 'self-disclosure' to describe a situation in which cancer patients openly discuss their diagnosis and thoughts and feelings about their disease with others (Yoo et al., 2010; Van Der and El 2013).

Quantitative studies have found that the failure to disclose feelings and concerns is associated with low emotional well-being in patients (Reid-Arndt et al., 2009); furthermore, good family communication and higher levels of perceived family support are associated with lower psychological distress in both male and female patients (Hasson'Ohayon et al., 2010; Northfield and Nebauer 2010). On the other hand, others have doubted the assumption that disclosure is good for cancer patients; for example, one study reported that patients often did not like to talk about their impressions with nurses, and instead, they decided to only talk about 'normal life', 'their hobbies' and 'families' (McLeod et al., 2010). Gray (2000) argued that there is no reason to suspect that it is psychologically or socially more adaptive to disclose to family, friends, and acquaintances than to not disclose (Gray et al., 2000).

As self-disclosing breast cancer diagnosis appears to play an important role in many health outcomes, and although there is a large body of literature about physicians' ethical obligation to disclose information to patients "and some research on family communications about breast cancer disclosure to family and friends, self-disclosure of BC diagnosis by Iranian women to

friends and colleagues has not been examined". Thus, we wanted to determine employed Iranian women's status of BC diagnosis self-disclosure to parents, siblings, patients' family, children, husband's family, friends, work colleagues and bosses/managers.

Materials and Methods

We conducted a retrospective study among employed Iranian women ($n=175$) who were referred to the hospitals of the Mashhad University of Medical Science in Razavi Khorasan province, Iran, between April 2001 and April 2011, after being diagnosed with breast cancer. Razavi Khorasan province is in north-eastern Iran, and has a population of ~5.9 million (Statistical Center of Iran). The hospitals selected for this study are cancer treatment centres from this province that serve as referral sites for cancer patients in north-eastern Iran.

Data were collected through a questionnaire survey. The questionnaire was developed in consultation with 10 faculty members and 10 patients. Women were included in the study if they met the following inclusion criteria: *i*) They were Iranian nationals; *ii*) They could speak and complete the interview; *iii*) They were within the age range of 20-60 years; and *iv*) They were employed for at least six months before the diagnosis of BC.

The inclusion criteria were fulfilled by 175 women (70%) who were working at the time of diagnosis of breast cancer. Patients were excluded if (a) they were housewives, (b) they did not have governmental jobs or (c) they retired after their diagnosis.

The patient demographics and clinico-pathological parameters including age, education and marital status, place of residence, lifestyle, income, household income, full-time employment status, number of years after breast cancer diagnosis, type of breast cancer, grade, type of surgery and auxiliary lymph node dissection were studied.

The status of support by parents, siblings, patients' family, children, husband's family, friends, work colleagues and bosses/managers was determined through the following question: Did your parents, siblings, family, children, husband's family, friends, work colleagues and boss/manager each support you after your cancer diagnosis?

The status of self-disclosure was determined through the following questions: *i*) Are your friends, boss and colleagues aware of your breast cancer diagnosis?; *ii*) What were your reasons for not disclosing your breast cancer diagnosis?; *iii*) Who diagnosed you with breast cancer?

The data were analysed using SPSS version 11.5. A descriptive analysis was used to assess the patient and disease characteristics for breast cancer diagnosis. The patient demographics and clinical characteristics were described by the frequency and percentage for the categorical data and by the means and standard deviations for the continuous descriptors. Frequency tables were generated to report the descriptive statistics. A P value of less than 0.05 was considered significant in all statistical analysis. Statistical analysis was performed using the chi-square test for associated self-disclosure

with demographic/disease characteristics.

Results

From 250 medical records, 175 (70%) questionnaires were completed. Data were gathered by phone interview on determining the status self-disclosure of BC diagnosis in employed women. Some interviews were not completed for various reasons, for example, lack of interest or time. The mean age at the time of breast cancer diagnosis was 44.3±6.7 years. The respondents' educational statuses were as follows: 4 (2.2%) illiterate; 40(22.9%) elementary or high school diploma; and 131 (74.9%) postsecondary education. The marital statuses of participants were as follows: 140 (80%) married; 21 (12%) single; 10 (5.7%) widowed; and 4(2.3%) divorced. Respondents' places of residence were as follows: 160 (91.4%) in a city and 15 (8.6%) in a village. The respondents' living statuses were as follows: 154 (88%) with their husband or children; 8 (4.6%) with parents; and 13 (7.4%) alone. The mean income of patients was 502,643×10(SD±147,185) and the household income in riyals was 948,037×10 (SD±406,921). Most women (127; 72.6%) were employed

full time. The mean number of years after breast cancer diagnosis was 3.91±1.89 years. Table 1 lists the characteristics of clinical breast cancer.

Over two-thirds of women had disclosed their breast cancer diagnosis to friends, children, siblings, partners, the patient's family and the husband's family (Table 2), bosses or supervisors, whereas around one-half had disclosed it to work colleagues (Table 3) but not to others. Reasons given for non-disclosure are shown in Table 4. Over 60% self-disclosed to work colleagues and over 90%, to bosses/managers. One hundred and twenty-three patients (70%) reported that they had support from their family and their husband's family, while 166 (95%) reported that they had support from parents, siblings, children and friends.

Discussion

The aim of this cross-sectional study was to determine the level of self-disclosure of BC diagnosis amongst employed women in Iran. A remarkable majority of employed women chose to freely disclose their breast cancer diagnosis to family and friends, and this usually resulted in more support, greater closeness and more information (Robinson and Tian 2009). It seems that some patients did not feel ready to inform others due to their own adjustment issues and/or not feeling ready to face others' reactions. In the context of a chronic medical illness, the importance of self-disclosure has been stressed. Open communication and self-disclosure are beneficial for patients, and Social adjustment has frequently been made.

Although the stigma of breast cancer is far less than it used to be, it seems that the effect of disclosing BC may occasionally remain problematic for some employed women in certain work situations. In relation to this observation, a recent report has suggested that survivors should not voluntarily disclose their cancer diagnosis in a job interview unless it directly affects their ability to perform that job; instead, they should stress their abilities and qualifications for the job (Stewart, et al. 2001). It seems that cultural factors play a significant role in self-disclosure of BC diagnosis in Iran. While disclosure can have advantages for individuals and their significant others, women must be assured that the benefits of doing so will outweigh the potential costs.

In conclusion, the results of this study clearly suggest that most employed women who survive breast cancer do not experience difficulties related to disclosure of the BC diagnosis; however, a significant minority report negative effects on relationships with friends, family and in the work environment. It may be helpful for women who have recently been diagnosed with breast cancer to be aware of the potentially negative effects that may result from indiscriminate disclosure of their cancer history; instead, they should disclose the diagnosis only to those who are likely to be supportive or helpful in the longer term. A full understanding of this issue will help to improve theoretical models of the health effects of disclosure and identify factors involved in the well-being of employed women with BC. Health professionals and cancer survivors should engage in education about the potential positive and negative effects of self-disclosure.

Table 1. Characteristics of the Clinical Breast Cancer

	Non metastatic	Metastatic	Total
	No. (%)	No. (%)	No. (%)
Type breast cancer	149 (85.1)	26 (14.9)	175 (100)
Breast cancer stage	1, 2	3, 4	
	109 (62.3)	66 (37.7)	175 (100)
Mastectomy	124 (70.9)	51 (29.1)	175 (100)
Auxiliary lymph node dissection	149 (85.1)	26 (14.9)	175 (100)

Table 2. Breast Cancer Discloses in Employed Women Survivors Breast Cancer "who have you told"

	Yes	No	Total
	No. (%)	No. (%)	No. (%)
Parents	161 (92)	14 (8)	175 (100)
Sibling	128 (73.1)	47 (26.9)	175 (100)
Patients family	128 (73.1)	47 (26.9)	175 (100)
Children	111 (63.4)	64 (36.6)	175 (100)
Husband family	152 (86.9)	23 (13.1)	175 (100)
Friends	109 (62.3)	66 (37.7)	175 (100)

Table 3. Breast Cancer Discloses to Work Colleagues, Boss/Supervisor

	Yes	No	Total
	No. (%)	No. (%)	No. (%)
Work colleagues	106 (60.6)	69 (39.4)	175 (100)
Boos/Supervisor	117 (66.9)	58 (33.1)	175 (100)

Table 4. Reasons for Non-disclosure of Breast Cancer Diagnosis in Employed Women

	No. (%)
Pity	48 (41.0)
Constant questioning of the diseases	5 (4.3)
Disappointment speech	8 (6.8)
Shame and embarrassment	6 (5.1)
Pity, Constant questioning, disappointment speech, Shame and embarrassment	50 (42.7)
Total	117 (100)

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References

- Badr H, Carmack CL, Kashy DA, et al (2010). Dyadic coping in metastatic breast cancer. *Health Psychology*, **29**, 169.
- Dagan M, Sanderman R, Hoff CH, et al (2013). The interplay between partners' responsiveness and patients' need for emotional expression in couples coping with cancer. *J Behav Med*, [Epub ahead of print].
- El-Sayed NO, Ali ZH (2009). Effect of Counseling Intervention Post Mastectomy for Women Undergoing Adjuvant Chemotherapy on their Quality of Life.
- Else-Quest NM, LoConte NK, Schiller JH, et al (2009). Perceived stigma, self-blame, and adjustment among lung, breast and prostate cancer patients. *Psychology Health*, **24**, 49-64.
- Frazier LM, Miller VA, Horbelt DV, et al (2009). Employment and quality of survivorship among women with cancer: domains not captured by quality of life instruments. *Cancer Control J Moffitt Cancer Center*, **16**, 57.
- Gray RE, Fitch M, Phillips C, et al (2000). To tell or not to tell: patterns of disclosure among men with prostate cancer. *Psychooncology*, **9**, 273-82.
- Harirchi I, Kolahtoozan S, Karbakhsh M, et al (2011). Twenty years of breast cancer in Iran: downstaging without a formal screening program. *Ann Oncol*, **22**, 93-7.
- Hasson-Ohayon I, Goldzweig G, Raun M, et al (2010). Women with advanced breast cancer and their spouses: diversity of support and psychological distress. *Psychooncology*, **19**, 1195-204.
- Jemal A, Bray F, Center MM, et al (2011). Global cancer statistics. *CA Cancer J Clin*, **61**, 69-90.
- Johnsson A, Fornander T, Rutqvist LE, et al (2009). Predictors of return to work ten months after primary breast cancer surgery. *Acta Oncol*, **48**, 93-8.
- Kolahtoozan S, Sadjadi A, Radmard AR, Khademi H (2010). Five common cancers in Iran. *Arch Iran Med*, **13**, 143-6.
- McDowell ME, Occhipinti S, Ferguson M, et al (2010). Predictors of change in unmet supportive care needs in cancer. *Psychooncology*, **19**, 508-16.
- McLeod DL, Tapp DM, Moules NJ, et al (2010). Knowing the family: interpretations of family nursing in oncology and palliative care. *Eur J Oncol Nurs*, **14**, 93-100.
- Mehnert A (2011). Employment and work-related issues in cancer survivors. *Crit Rev Oncol Hematol*, **77**, 109-30.
- Northfield S, Nebauer M (2010). The caregiving journey for family members of relatives with cancer. *Clin J Oncol Nurs*, **14**, 567-77.
- Park CL (2010). Making sense of the meaning literature: an integrative review of meaning making and its effects on adjustment to stressful life events. *Psychol Bull*, **136**, 257.
- Petersson, LM, Wennman-Larsen A, Nilsson M, et al (2011). Work situation and sickness absence in the initial period after breast cancer surgery. *Acta Oncol*, **50**, 282-8.
- Reid-Arndt SA, Yee A, Perry MC, et al (2009). Cognitive and psychological factors associated with early posttreatment functional outcomes in breast cancer survivors. *J Psychosoc Oncol*, **27**, 415-34.
- Robinson JD, Tian Y (2009). Cancer patients and the provision of informational social support. *Health Commun*, **24**, 381-90.
- Stewart DE, Cheung AM, Duff S, et al (2001). Long-term breast cancer survivors: confidentiality, disclosure, effects on work and insurance. *Psychooncology*, **10**, 259-63.
- Tammaing SJ, De Boer AG, Verbeek JH, et al (2012). Breast cancer survivors' views of factors that influence the return-to-work process-a qualitative study. *Scand J Work Environ Health*, **38**, 144-54.
- Tiedtke C, de Rijk A, Dierckx de CB, et al (2010). Experiences and concerns about 'returning to work' for women breast cancer survivors: a literature review. *Psychooncology*, **19**, 677-83.
- Van Der Velden M, El Emam K (2013). Not all my friends need to know: a qualitative study of teenage patients, privacy, and social media. *J Am Med Inform Assoc*, **20**, 16-24.
- Yoo GJ, Aviv C, Levine EG, et al (2010). Emotion work: disclosing cancer. *Support Care Cancer*, **18**, 205-15.