

Family functionality and coping strategies in patients with breast cancer

Abstract

Objective: To determine the relationship Between family functionality and coping strategies in breast cancer patients.

Methods: Descriptive, cross-correlation study. A Total of 63 women with a breast cancer of between 2 and 24months of evolution were studied diagnosis. Sociodemographic variables, treatment received, associated comorbidity and the coping strategy used, as measured by the "Inventory of Coping Strategies" and functional variables measured family relationship family function with the FFSIL Perception questionnaire. The information was processed using the Obtained statistical package SPSS 23, descriptive statistics Analyzed With Pearson, X2 and relative risk.

Results: The most used was the active coping strategy type in 68% of the women Studied, with problem resolution The most frequent being in 43%. Factors related to active coping Were age ($p=0.019$), marital status ($p=0.013$), and adequate family functionality ($p=.000$).

Conclusion: Adequate family functionality is a protective factor for active coping strategies in breast cancer patients.

Keywords: coping, breast cancer, family functionality

Volume 9 Issue 5 - 2018

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Received: May 25, 2018 | **Published:** October 18, 2018

Introduction

The family is a system variable structure in which its members interact, grow and develop throughout life; always subject to external factors that influence positively or negatively on its composition and interactions so that family functioning is the ability to face and overcome each of the stages of the life cycle and crises being experienced. Within the study of family functioning has become very important to be demonstrated in several studies the influence on the health of its members.¹⁻⁵ The assessment of family functionality in family medicine has specific characteristics that differentiate it from which can be performed by other disciplines, because it has the fundamental purpose of comprehensively understanding the context in which the pathology is produced by allowing reorient their treatment different solutions to those traditionally offered, contributing elements to the biopsychosocial vision that characterizes familiar^{3,4} medical attention. Breast cancer is suffering from a stressful event that threatens significantly in different areas and decay can occur daily activities and cause negative emotional states in patients; so it is important to evaluate and understand the impact of the disease and treatment on perceived welfare of the patient; that assessment should be comprehensive and individualized to each woman considering the physical, social and psicológico^{6,7} appearance.

Family before the diagnosis of cancer suffers widespread collapse characterized by a crisis of organization, the entire system is teetering and requires a restructuring to adapt to the needs of attention and care to be provided to the patient. Also accompanied this crisis, physical, economic and emotional stress in the family, resulting in a total imbalance in the pace and lifestyle. Sometimes even it required support from family and friends to meet these needs. Subsystem subsidiary children of these patients suffer from estrangement with the

mother, sometimes are older siblings who are in charge of their care; This causes a strong change in the care they receive as personal care, food and general support that the mother provides. There are families in which the disease in addition to the above causes separation from parents, causing increased involvement of children as they suffer the loss of the mother and father absence. With respect to marital subsystem, for most women the support of their partners during illness is essential to being considered the best possible physical and psychological support. In some cases the disease strengthens their relationship, especially when they are able to express their concerns and fears of the other person. Another reason may be compromised relationship is loss of sexual activity, this dysfunction is more evident in those patients who are undergoing mastectomy, because it causes decrease or even cease their sex describing a worsening of their feelings of sexual attractiveness and comfort when having sex; as well as a perception that sexual interest your partner has also decreased. As seen, the disturbances in patients with breast cancer is not only focused on the physical appearance of disease but this conditions a series of events in the family, sexual laboral⁸⁻¹¹ even field.

The impact caused not only known with a serious illness but having to undergo changes in their physical appearance produces different emotions, but the presence and intensity with which they manifest, will be mediated by coping styles with those who are counted. These emotional states affect health directly either in physiological functioning, symptom recognition, seeking timely care; as well as conducting saludables.^{6,7,12} El not coping behaviors is a kind of response that is generated to a stressful situation, ie are the tools and resources that the individual develops to handle external and/or internal situations that exceed the individual's resources. Active coping with a serious illness is associated with a reduction in stress associated with the disease. Moreover it has been shown that passive

coping results in a deterioration in the quality of life, it is associated with accelerated disease progression and an increase in emotional stress. While most stressors generate both coping responses, you may predominate one of them, there is no response better coping than others, but these turn out to be functional or dysfunctional to the extent that they are useful for adaptation to the stressor. Evidence of adequate coping is reflected in the psychological and emotional well-being of the patient, and if not psychological distress occurs also affects physical health and performance in general.¹³⁻¹⁶

Coping styles that uses patient depends on several factors among which are: characteristics of the disease, the type of pathology, disease stage, given treatment, patient characteristics (age, marital status, education, occupation, socioeconomic status), as well as relations with the patient's environment (type of family, marital satisfaction, social support, family functioning), ie women is part of a system so diagnosis and treatment proposed are not the only cause of stress or emotions you experience, there are other circumstances such as economic problems, recent losses, a family history of breast cancer, etc.^{12,17} Women who have high levels of self-esteem, social support and better coping styles have a greater psychological well-being, as the emotional suffering of patients is mainly due to the meaning attributed to the events of the disease, ie the intensity with which they live they will depend on coping skills and personality characteristics of each patient.^{9,12} Given the above it is essential to understand the family structure individually for each cancer patient as well as the cultural, social and spiritual meaning that cancer and its treatment in general has for them; I understand the different cultures of each family group and their different ways of coping;

The objective of this study is to identify the relationship between family functioning and coping strategies of patients with breast cancer and the factors that could relate to such strategies.¹⁸

Methods

Descriptive, cross correlation study in patients with breast cancer diagnosed in the year 2014-2015 the General Hospital of Zone 46 of the Mexican Social Security Institute, Delegation Tabasco cancer. He interviewed the patients in the outpatient department of medical oncology and others in the chemotherapy room. Test Perception of Family Functioning (FF-SIL) which measures the perceived family functioning as systemic dynamic relationship was used to evaluate the familiar functionality. The test consists of 14 propositions and 7 categories that define family functioning: Cohesion (Question 1 and 8): physical and emotional to face different situations and decision-making of family togetherness everyday tasks. Harmony (question 2 and 13): correspondence between the individual interests and needs with those of the family in a positive emotional balance. Communication (Question 5 and 11): the family members are able to convey their experiences clearly and directly. Permeability (question 7 and 12): capacity of the family to provide and receive experiences of other families and institutions. Affectivity (Question 4 Y 14): ability of family members to experience and demonstrate positive feelings and emotions each other. Roles (question 3 and 9): each member of the family fulfills the responsibilities and roles negotiated by the family. Adaptability (Question 6 and 10): Family ability to change power structure, relationship roles and rules in a situation that requires it. There is a scale of 5 qualitative responses to each situation, they in turn have a point scale that are almost never 1 point, 2 points

rarely, sometimes 3 points, 4 points often, almost always 5 points. Each situation is answered by the user by a cross (x) in the range of qualitative values, as perceived by family member. At the end the sum of the points is performed, which correspond to a scale of categories to describe family functioning as follows: 70-57 functional family, 56-43 moderately functional family, 42-28 Dysfunctional family, 27-14 5,13 severely dysfunctional family. almost always 5 points. Each situation is answered by the user by a cross (x) in the range of qualitative values, as perceived by family member. At the end the sum of the points is performed, which correspond to a scale of categories to describe family functioning as follows: 70-57 functional family, 56-43 moderately functional family, 42-28 Dysfunctional family, 27-14 5,13 severely dysfunctional family. almost always 5 points. Each situation is answered by the user by a cross (x) in the range of qualitative values, as perceived by family member. At the end the sum of the points is performed, which correspond to a scale of categories to describe family functioning as follows: 70-57 functional family, 56-43 moderately functional family, 42-28 Dysfunctional family, 27-14 5,13 severely dysfunctional family.

To assess coping used the "Inventory of coping strategies (CSI) Spanish version of Otero et al., 1998". This instrument is made up of 40 items with Likert response format type 5 points, from 0 to 4, assesses the degree of use of active coping strategies and passive stress coping. It consists of eight primary scales, of which 4 correspond to active strategies and 4 to passive coping strategies coping. Strategies first group problem solving (cognitive and behavioral strategies to eliminate stress by changing the situation that produces it), cognitive restructuring (change the meaning of the stressful situation), social support (search for emotional support) and emotional expression (release of emotions that occur in the process of stress). While passive coping strategies that measures are: avoidance of problems (negotiation and avoidance of thoughts or related to the stressor acts), social withdrawal (withdrawal from friends, family, peers and significant others associated with the emotional reaction in stressful process) and self (self-blame and self-criticism by the occurrence of the stressful situation or improper handling). Reliability for each of the scales in a study in 25 women diagnosed with breast cancer who were receiving treatment in the city of Santiago were problem solving (0.69), emotional expression (0.70), social support (0.77), cognitive restructuring (0.77), criticism (0.84), wishful thinking (0.80), avoidance of problems (0.60) and social withdrawal (0.64). In addition the existing reliability among the four active strategies (0.85) and the four passive strategies (0.75) 14.17 was estimated. The information processing was performed using the SPSS (Statistical Package for the Social Sciences) version 23 for Windows. information with descriptive statistics were analyzed by frequency tables and percentages and analysis with Spearman's rho, and X2 Pearson was performed and the relative risk was analyzed.

Results

63 women studied, the average age was 49 years (34-88) predominance of married 35%, schooling baseline in 44%, housewife 50% and rural residence in 69% (Table 1). Regarding the clinical 70% denied comorbidities. 40% were 24 months of evolution, 44% was found in stage 2 and 62% are receiving chemotherapy (Table 2). 46% were evaluated as moderately functional families, and the major dimension with impaired communication was 30% (Table 3). 68% had active coping, with problem solving strategy most used by up to 43% of the patients studied (Table 4) (Table 5). Age and marital status had positive relationship with the active coping $p=0.019$,

$p=0.013$ respectively. No relationship between occupation, education level, place of residence, comorbidity, duration, stage of disease and treatment established coping strategies (Table 6) was found. Family functionality provided closely with active coping ($p=.000$) and altering the dimension family communication provided positive relative to the negative coping ($p=0.003$) (Table 7) (Table 8). Regarding the prevalence ratio, those women who were perceived with proper family functioning were 7 times more likely to use active coping strategies. Family functionality provided closely with active coping ($p=.000$) and altering the dimension family communication provided positive relative to the negative coping ($p=0.003$) (Table 7) (Table 8). Regarding the prevalence ratio, those women were perceived with proper family functioning were 7 times more likely to use active coping strategies. Family functionality provided closely with active coping ($p=.000$) and altering the dimension family communication provided positive relative to the negative coping ($p=0.003$) (Table 7) (Table 8). Regarding the prevalence ratio, those women who were perceived with proper family functioning were 7 times more likely to use active coping strategies.

Table 1 Socio-demographic data of patients with breast cancer general hospital of zone 46

Scholarship	F	%
Literate	4	6.3
Primary	7	11.1
High school	twenty-one	33.3
Baccalaureate	19	30.2
Bachelor's degree	10	15.9
Postgraduate	2	3.2
Civil status	F	%
Single	32	50.8
With couple	31	49.2
Occupation	F	%
Housewife	32	50.8
Worker	9	14.3
Own business	18	28.6
Pensionada	4	6.3
Place of residence	F	%
Rural zone	9	14.3
Urban zone	19	30.2
Suburban area	35	55.5

Table 2 Clinical data of patients with breast cancer general hospital zone 46

Disease stage	F	%
Stage 1	9	14.3
Stage 2	28	44.4

Table Continued...

Stage 3	2.3	36.5
Stage 4	3	4.8
Established treatment	F	%
Partial mastectomy	1	1.6
Radical mastectomy	fifteen	23.8
Chemotherapy	39	61.9
Radiotherapy	8	12.7
comorbidity	F	%
No sickness	44	69.8
Rheumatoid arthritis	1	1.6
Mellitus diabetes	14	22.2
Hypertension	4	6.3

Table 3 Family functioning of patients with breast cancer general hospital of zone 46

Source: Instrument FFSIL for family functioning. n=63

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	F	%
Functional family	26	41.3
Moderately functional family	29	46
Dysfunctional family	7	11.1
Severely dysfunctional family	1	1.6

Table 4 Strategy coping of patients with breast cancer general hospital zone 46

Source: Coping strategies inventory otero version. n=63

	F	%
Active	43	68.3
Passive	twenty	31.7

Table 5 Type coping strategy of patients with breast cancer general hospital zone 46

Source: Coping strategies inventory otero version. n=63

	F	%
Problem resolution	27	42.9
Cognitive restructuring	1	1.6
Social support	13	20.6
Emotional expression	2	3.2
Social withdrawal	1	1.6
Self-criticism	10	15.9
Avoidance of the problem	0	0
Thought Desiderative	9	14.3

Table 6 Socio-demographic data and coping strategy of patients with breast cancer general hospital zone 46

Source: Questionnaire sociodemographic data and Inventory of coping strategies n=63

		Coping						
		Active		passive				
variables		ff	%	F	%	gl	x2	p
Age	48-60 years	14	22.2	9	14.2	26	43001	0.019
Civil status	married	fifteen	23.8	7	11.1	5	14,513	0.013
Scholarship	High school	14	22.2	7	11.1	5	8,532	0.129
Occupation	Housewife	22	34.9	10	15.8	3	3.58	0.31
Place of residence	Suburbana	25	39.68	4	6.3	2	6,231	0.044

Table 7 Family functioning and coping strategy of patients with breast cancer general hospital zone 46

Source: Inventory of coping strategies and family perceptions questionnaire functionality FFSIL n=63

	Active		passive				
	F	%	F	%	v	x2	P value
Functional family	42	66.6	12	19	1	15,823	.000
Dysfunctional family	1	1.5	8	12.6			

Table 8 Dimensions of family functioning and coping strategies of patients with breast cancer general hospital zone 46

Source: Inventory of coping strategies and family perceptions questionnaire functionality FFSIL n=63.

Dimensions of family functioning		coping						
		Active		passive		v	x2	P value
		F	%	F	%			
Cohesion	unchanged	43	68.2	19	30.1	1	2,185	0.317
	with impaired	0	0	1	1.5			
Harmony	unchanged	41	65	19	30.1	1	0.004	0.952
	with impaired	2	3.1	1	1.5			
Roles	unchanged	41	65	17	26.9	1	2,001	0.178
	with impaired	2	3.1	3	4.7			
Affectivity	unchanged	42	66.6	18	28.5	1	1,773	0.183
	with impaired	1	1.5	2	3.1			
Communication	unchanged	35	55.5	9	14.2	1	8,585	0.003
	with impaired	8	12.6	eleven	17.4			
Adaptability	unchanged	41	65	19	30.1	1	0.004	0.952
	with impaired	2	3.1	1	1.5			
Permeability	unchanged	38	60.3	19	30.1	1	0.696	0.404
	with impaired	5	7.9	1	1.5			

Discussion

Breast cancer is a disease whose impact on the physical, psychological, social and economic level is of great importance, representing a para-regulatory crisis affecting women and their family and social environment, so the study of coping develop when diagnosis is extremely important to provide comprehensive management. Regarding the data striking finding patients outside the age range considered low risk for breast cancer 34 and maximum 88years, which coincides with the study by De Haro Rodríguez et al.¹⁷ where minimum age was 29years and maximum of 95. as the promotion of self-exploration and deliberate search of risk factors it is of great

importance. Of the women studied who received surgical treatment, in any conservative surgery which coincides with the findings in the same studio, where he associated with stages of very advanced disease was made, however, in our work the most frequent stages were stage 2 and 3, however these types of surgeries carries greater risk for recidivism. Although the perception of family functionality is mostly found in functional and moderately functional families, it is striking that in all considered that there was no proper communication in your family, similar to those obtained by Falo Zamora et al.,¹⁹ (2014) data. Most have a nuclear family (married and common law) which coincides with studies by De Haro Rodríguez et al.¹⁷

Most women in the study used active coping strategies, primarily aimed at solving the problem, data that matches most studies in the Mexican population. According to what I found, women with partners mostly presented active coping with significance statistics and positive association in relative risk being a protector for the strategies of active coping factor, we might consider those single women and increased risk of passive coping strategies which several authors associated with depressive states and anxiety, which coincides with Micaela results obtained by Reich et al.²⁰ Age showed a positive relationship with active coping strategy, the school and higher education showed a strong association with active coping strategies presenting statistical significance, which coincides with other studies,^{17,20} medical treatment was not related to coping strategies employed which differs from other studies, it may be because most patients already have longer under treatment (24 months). Although our results are consistent with De Haro Rodríguez where family structure is related to active coping strategies, our work has studied the perception of family functionality found that proper family functioning has positive association so it can be considered a factor protector for such strategies.²¹

Conclusion

Active coping strategies are the most commonly used in women with breast cancer, with problem solving predominates in most patients, which is related to factors such as age, education and marital status. No relationship of coping strategies with the disease stage, treatment or the presence of comorbidities was found. Most patients of the study have a perception of family functionality and functional, although in all the dimension of communication I present low values, so that working in this area to achieve a clear and direct communication thus achieving better understanding of pathology at the family level.

Acknowledgements

None.

Conflict of interest

The author declares no conflict of interest.

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