

# **PSYCHOLOGICAL DETERMINANTS OF POST-OPERATIVE RECOVERY AMONG MASTECTOMY CLIENTS: A FOCUS ON POST-SURGERY SELF-PITY AND POST-SURGERY SOCIAL SUPPORT**

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## **ABSTRACT**

The aim of this study is to investigate the influence of post-surgery self-pity and post-surgery social support on post-operative recovery among mastectomy clients. The study adopted a correlational research design and employed the use of questionnaire to collect primary data from clients that undergo mastectomy between 2010 and 2013. Data analysis was done using descriptive while the Pearson product moment correlation was used as the statistic, relying on SPSS version 20.0. The findings are that post-surgery self-pity does not support quick recovery of mastectomy clients while a positive and significant relationship was found between post-surgery social support and post-operative recovery. The study therefore concludes that psychological factors such as post-surgery self-pity and post-surgery social support affect convalescence of mastectomy, and recommends that guidance counsellors and other care givers must ensure that they discourage clients from indulging in self-pity in order to enhance their chances of enjoying quick post-operative recovery and that guidance counsellors and care givers should offer and also solicit the support of friends and families of their clients to assist the clients in every aspect of the post-operative recovery process; as this is found to support quick post-operative recovery.

**Keywords:** Mastectomy clients, psychological determinants, post-surgery self-pity, post surgery social support.

## **INTRODUCTION**

It is common to see individuals who undergo mastectomy wallow in sorrow following the removal of their mammary gland(s). These individuals struggle with self-denial and often wish for death, rather than lose what they term as the substance of their femininity. They spend long hours crying every day during their stay in the hospital; and refuse all forms of consolation. They also try to keep the affected breast away from people. Also, it is observed that there is usually a disparity in the length of time different individuals spend in the hospital after mastectomy (Mital et al, 2004). This disparity in the pace of recovery of individuals who undergo mastectomy may be explained by many variables; since all patients are given almost the same medical attention.

Psychological variables such as post-surgery anxiety, post-surgery self-pity, post-surgery depression, post-surgery self-esteem, post-surgery social support among others have either been identified or feared to affect medical conditions as supported by a growing body of research. Yet, the tendency to look mostly to medicine and medical remedies to aid patient recovery has been the order. Though psychologist and counsellors have had to be called in to

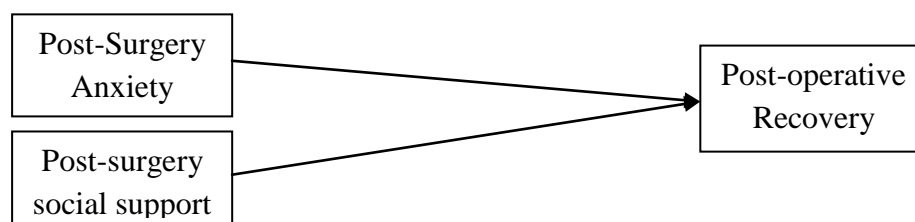
help mastectomy patients on rare occasions especially in the advanced western societies, this practice is yet to be fully utilised in the developing societies.

The crisis that mastectomy patients experience is not something peculiar to them since human beings in general tend to consciously pursue pleasure and avoid pain. Higgins' (1997) theory of regulatory focus states that individuals are motivated to promote goals of advancement, growth and achievement and to prevent insecurity, instability and loss. However, as life unfolds, people find that there are certain unpleasant states that they cannot totally avoid. Such states which include, but not limited to ailments have deprived individuals of the good life in more ways than one, and have put them in states that they do not wish for.

This study is thus intended to determine the relationship between post-surgery anxiety and post-surgery social support as a psychological variables and post-operative recovery among mastectomy clients; and also to suggest how counsellors and other care givers can assist mastectomy clients in their post-operative recovery. Consequently, the following research hypotheses are formulated to guide the study:

Ho<sub>1</sub>: There is no significant relationship between post-surgery anxiety and post-operative recovery among mastectomy clients.

Ho<sub>2</sub>: There is no significant relationship between post-surgery social support and post-operative recovery among mastectomy clients.



## LITERATURE REVIEW

Studies suggest that individuals usually have one or more clinical, psychological or behavioural variables that interfere with their recovery after a surgical procedure (Dimsdale, 2013). Such factors are assumed to significantly affect an existing condition, or interfere with the recovery of the individual. These factors may increase the risk of suffering, fatality, or prolong the duration of the individual's stay in the hospital (Crosta, 2009). Such psychological factors include, but not limited to anxiety, self-pity, depression, loss of self-esteem and perceived social support (Crosta, 2009; Stöber, 2003; Kiece-colt-Glaser et al, 1995). The current study however, takes a look at how post-surgery anxiety and post-surgery social support impacts on the recovery of individuals that undergo mastectomy.

### Post-surgery Self-pity

Individuals frequently resort to self-pity as a way of responding to events and occurrences in life which are stressful, disappointing or frustrating. In various life situations and events, such as personal failure or illness, self-pity is a prevalent response (Stöber, 2003). The term pity may be discerned to mean compassionate and heartfelt sorrow directed at someone that suffers physical, mental or any distressful or unhappy conditions. Self-pity is thus a compassionate and heartfelt sorrow directed toward the self. It may be conceived as a sympathetic, heartfelt sorrow for oneself prompted by one's own physical or mental suffering, distress, or unhappiness (Stöber, 2003). Often, self-pity is accompanied by feelings of sadness, loss and a heightened sense of injustice (Charmaz, 1980).

According to Grunert (1988), it is common for individuals who feel self-pity to envy others who have not suffered similar experiences as they have. They usually express their envy in statements like why me and not others, or what did I do to deserve this. Statements like this typically accompany the internal monologue associated with experiences of self-pity (Charmaz, 1980). The feeling of self-pity is neither restricted to mastectomy patients nor individuals suffering from chronic illness or severe losses. It is rather an emotional experience which all humans encounter at some point in life; since life holds many opportunities for one to feel sorry for oneself. Feelings of self-pity do not arise only at critical life junctures in life such as undergoing a surgery or losing a loved one, but also at minor junctures such as being rebuffed by someone or simply not getting enough attention from relevant others (Kahn, 1965).

There is considerable agreement among scholars that self-pity is an emotional reaction that manifests in times of severe trauma or stress (e.g., Elson, 1997; Wilson, 1985; Kahn, 1965). The tendency of individuals to react to stress by feeling sorry for their selves however, shows great individual differences relating to certain personality characteristics. Based on clinical experience, (Kahn, 1965) suggests that self-pity significantly affect individuals who are characterized by great self-insecurity when confronted with problems or adverse situations. Such individuals are less likely to be able to cope effectively with stress than those who are emotionally stable, and are thus likely to react over sensitively in the face of situational difficulties that others might easily brush off. This more so, as a close connection have been established between self-pity and individual depression with individual differences playing a mediating role (Grunert, 1988).

Studies suggest that self-pity negatively affects convalescence (Smith & MacKenzie, 2006; Cordova et al, 2003; Scheier et al, 1994, 1989). Self-pitying persons are usually more likely to overindulge in their failures, hardships, and losses, and the circumstances elicited by these setbacks, thus becoming self-consciously preoccupied with their own suffering (Charmaz, 1980). Nonetheless, Kahn (1965) opine that self-pity is not an emotional response directed exclusively towards the self, saying that whereas the primary focus in self-pity may be on the self, it also has a strong interpersonal component. Quite often, self-pity is an emotional response directed towards others with the goal of attracting attention, empathy or help (Kahn, 1965).

Indulging in self-pity as a coping strategy or as a way of attracting attention and empathy is not always a gainful enterprise because it is a strategy that will fail in the long run. Though initial display of self-pity may evoke empathy from others (Milrod, 1972), pervasive self-pity will not only fail to sustain such empathy, but could actually put others off. People who indulge in self-pity excessively are more likely to be rejected. Even for individuals who suffer from chronic illness, the period of time is quite limited during which the social environment will allow for a display of self-pity (Stöber, 2003).

After the initial shock, people are expected stop complaining and carry on with their lives (Charmaz, 1980). Thus, John W. Gardner suggests that self-pity is easily the most destructive of the non-pharmaceutical narcotics; as it is addictive, gives momentary pleasure and separates the victim from reality, implying that one sure way that may not assist one in overcoming obstacles is indulging in self-pity; since individuals with a high degree of self-pity often report emotional loneliness and ambivalent-worrisome attachments (Milrod, 1972).

### **Post-surgery Social Support**

Social support is the belief one has regarding how one is cared for, get assisted by others and feels being part of a supportive social network (Wills, 1985). The form of support gotten may be emotional, tangible and intangible, informational or companionship (Wills, 1985). Social support may be assessed by the level of assistance available, the actual assistance received or the degree to which a person is integrated in social network. It can come from many sources including relevant others, organisations (Uchino, 2004), as well as public aid.

Social support is commonly linked with increased social and psychological wellbeing (House, 1981) in response to important life events (Cobb, n.d). Psychological distress such as anxiety and depression that attend stressful events in life are usually reduced when individuals enjoy social support. Social support which also functions as an emotion-focused coping strategy has been found to promote psychological adjustment in conditions with chronic high stress like cancer and coronary heart disease (Holahan et al, 1997; Holahan et al, 2000; Holahan et al, 2005). Persons that do not enjoy social support are more likely to report sub-clinical symptoms of depression and anxiety than persons that enjoy social support (Cohens and Wills, 1985). It is also opined that people with high social support are less likely to experience major mental disorder than people with low social support.

Relationship between partners may suffer because of breast cancer, since the diagnosis can be highly distressing for a loved one. Quite often, a spouse is unsure of how the diagnosis and treatments are going to play out in their future; and may be concerned about how to express their feelings physically and emotionally after treatment. This can be especially true after surgery; because they may be afraid they will somehow physically hurt their loved one. If the surgery has been recent, physical discomfort may be a reality. Talking to your partner openly and honestly about what you are feeling will help to keep the lines of communication open.

Thus, there are many benefits to social support. It has therefore been proposed that in order to maximize the benefits of social support, there must be a match between the social support desired by the recipient the social support given to him or her (Cutrona, 1990; Cohens & Wills, 1985; Cohens & McKay, 1984). This because the psychological stress that the individual is suffering may increase if there is no match between the social support sought and the social support given.

Another dimension of social support is the extent of effective communication that exists between the care givers and the clients since ineffective communication has been found to affect patients' post-operative recovery; in that the length of period surgical patients spend in the hospital decreases if they are given adequate information about their health and if they are encouraged to express their anxieties with regard to the coming operation (Johnson, 1966; Agbakwuru, 2013). In the light of these credible findings, it is important for the surgeon, anaesthetist, nurses, psychologists, counsellors, hospital staffs and significant others of the patients to help them gain insight into their health conditions. Such insights no doubt will help them reorganize themselves and brace up psychologically to face challenges posed by their health conditions. Also, empirical findings from the past decades show that clinicians' ability to explain, listen and empathize with their clients have a profound effect on biological and functional health outcome as well as patients' satisfaction, this helps to speed recovery (Agbakwuru, 2013).

### **Clients' Post-surgery Recovery**

When someone that ill returns to normal or improved health, the person is said to have recovered. Thus, recovery can be conceived as the return to normal or improved state of being after a setback. Post-operative recovery is an important part of patients' experience

after a surgical procedure. Although post-operative recovery is a commonly used concept, it has not lent itself to a universally acceptable definition; as different disciplines attribute different meanings to it. The apparent lack of clarity of the concept of post-operative recovery both to medical professionals and care givers in their care for surgical patients, and for researchers (Allvin, Berg, Idvall & Nilsson, 2006) notwithstanding, the concept has been a frequent subject of discourse.

There have been extensive research in the field of post-operative recovery, and have included studies of post-operative recovery as a measure of outcome, e.g. factors associated with length of hospitalization (Kehlet & Dahl, 2003), specific surgical procedures (Bay-Nielsen et al, 2004), and the use of specific pain management techniques (Allvin et al, 2006). The emphasis in qualitative studies is on patient experiences in post-operative recovery, and primarily focused on factors associated with specific diseases such as cancer (Burt et al, 2005; Olsson et al, 2002; Nilsson et al, 2002).

Early, intermediate and late recovery is the major divisions of post-operative recovery (Korttila, 1995; Steward & Volgyesi, 1978). The discontinuation of anaesthesia until patients have recovered their vital protective reflexes marks the early phase, while the period from when patients regain stable vital functions to the time they are ready for discharge marks the intermediate phase. The time from when the patient is discharged to the time the patient reach preoperative health and well-being marks the late post-operative phase (Marshall & Chung, 1999; Steward & Volgyesi, 1978).

Holistically, post-operative recovery can be described as a process defined by improvement in functional status and the perception that one is recovering (Zalon, 2004). It can also be described as a return to wholeness that occurs by conservation of energy and reinstatement of integrity (Levine, 1991). Pain, feelings of depression and fatigue are linked to patients' self-perceptions of post-operative recovery after mastectomy, abdominal surgery or coronary artery by-pass graft surgery (Zalon, 2004).

Patients also have major concerns about returning to independence in activities in daily life (Kirkevold et al, 1996; Moore, 1997). Physical sensations associated with fatigue, pain from chest and leg incisions, pain in shoulder and neck muscles, and pain while coughing are part of the recovery process (Moore, 1997). Pain and fatigue are the most common and severe symptoms in post-operative recovery (Moore, 1997; Zalon, 2004, Nilsson et al, 2006) and indicate impaired structural integrity after surgery (Zalon, 2004). According to Levine (1991), fatigue is a sign of limited energy resources, which is described as both physical and psychological energy loss (Nilsson et al. 2006).

Reduced energy and preoperative anxiety may cause post-operative fatigue (Nilsson et al, 2006). Also, pain, depression and fatigue are significantly related to functional status and self-perception of recovery in older post-operative mastectomy patients (Zalon, 2004). Psychological sensations are also part of the recovery process (Moore, 1997). Depressive feelings reduce the conservation of a person's self-worth and have been associated with lower functional status after surgery (Zalon, 2004). Signs of recovery include a continuous decrease in discomforting bodily symptoms (Olsson et al, 2002).

As a psychosocial phenomenon, recovery is the process of regaining strength that results to abandoning the sick role (Parsons, 1975). It culminates to getting discharged from the hospital as an outcome measure for factors associated with the length of period of hospitalization. At a behavioural level, recovery is defined as leaving the sick role to resume normal routines and returning to and healthy living including taking up social obligations and returning to work (Brown & Rawlinson, 1977). The psychosocial recovery process also



involves resuming interpersonal interactions and is more complex and time-consuming than recovery of self-oriented activities. Patients seem to focus on regaining physical, cognitive and practical functions before focusing on relating to others (Kirkevold et al, 1996).

When an individual becomes disabled, it is expected that treatment will be sought. When this happens, the individual becomes dependent on others for care. After a given period of time, caregivers help the patient develop the skills needed to take responsibility for self-care (Nilsson et al, 2006). To optimize the recovery process, patients require more detailed discharge information on what to expect after surgery (Theobald & McMurray, 2004).

Baker (1989) conceptualized recovery as a phenomenon that extends beyond discharge. This author described post-discharge recovery as a process of returning to normality, as defined by pre-illness comparative standards of physical, social and psychological well-being. Passivity, resumption to activity and stabilization are the successive phases in the post-discharge recovery. The passivity phase is a time of rest to support physical convalescence. At the resumption of activity phase, individuals prepare themselves for return to a full range of activities; while at the stabilization phase which starts when the patient has returned to a full range of pre-illness social roles and functions (Baker, 1989). Patients chose to resume full activities based on cues and pressure. Those who experience congruence of cues and pressures reports positive feelings about the recovery process while those who perceived negative physical symptoms especially fatigue, and who were unable to respond to pressures express frustration (Baker, 1989).

The recovery process includes decisive moments or indicators of recovery, defined as recovery trajectories (Baker, 1989). These critical moments in the trajectory can be identified as either improvements or setbacks in relation to expected outcomes (Lawler, 1991). The recovery trajectory is based on the belief that the patient will recover. There is a wide recovery trajectory, but also multiple smaller trajectories (Baker, 1989). Each trajectory is linked to the progress and control of bodily functions as patients move towards recovery; these shifts in control are defined as recovery markers (Lawler, 1991). Recovery thus can be described as becoming independent and regaining control over one's bodily function and body care (Lawler, 1991).

Concept analysis requires the determination of the defining attributes or characteristics that are most frequently associated with the concept and appear repeatedly in references to it (Walker & Avant, 2005). Based on this approach, the defining attributes of recovery after surgery are: (a) an energy-requiring process (b) a return to a state of normality and wholeness defined by comparative standards (c) regaining control over physical, psychological, social and habitual functions (d) returning to preoperative levels of independency/dependency in activities of daily living (e) regaining one's optimum level of well-being.

Several dimensions of post-operative recovery easily emerge from literature. One such post-operative recovery process is divided into four dimensions, i.e. physiological, psychological, social and habitual recovery (Walker & Avant, 2005). In physiological recovery, patients improve their functional status by regaining control over reflexes and motor activities, normalized and controlled bodily functions, loss of pain and fatigue and conservation of energy. Passivity is also a part of physiological recovery. Psychological recovery includes returning to psychological well-being and wholeness, reinstated integrity and the transition from illness to health (Walker & Avant, 2005).

Psychological recovery also includes experiences of pressures and cues. In the dimension of social post-operative recovery, the patient strives to become independent and to stabilize at full social function, which includes interacting with other people (Walker & Avant, 2005).

While in the habitual part of recovery, the patient works towards stabilizing the full range of activities by taking responsibility for and controlling activities in daily care, normal eating and drinking habits, returning to work and driving (Walker & Avant, 2005).

Several measures are commonly used as indicators of post-operative recovery. In this study however, we shall look only at duration of hospitalization and duration of sick leave. The measures are adopted from Persson and Kjølhede (2008). It is the considered view of this researcher that these measures are adequate and can be applied in different health environment and also in various kinds of post-surgery recovery situations.

### **Duration of Hospitalization**

The number of surgical procedures performed as day surgery has increased in recent times due to modern surgical technologies along with economic and political initiatives (Toftgaard, 2009). Day surgery indicates a short period of close monitoring at the surgery unit before the patient is discharged. After leaving the surgery unit, patients have to manage post-operative problems on their own with the help and support of their personal network (Boughton & Halliday, 2009; Young et al, 2000). However, most surgical procedures require thorough post-operative monitoring and evaluation requiring an extended stay in the hospital.

The length of time it takes for patients to be considered stable enough for discharge usually vary from patient to patient and is often determined by the type of surgery involved. Duration of hospitalization describes the total amount of time patients spend in the hospital before being certified for discharge. Generally, patients that undergo surgical operation are usually kept under surveillance for adequate monitoring and care. However, post-operative recovery is individual specific and entails a composite of different physical and psychological issues (Berg et al, 2012); and is influenced by type of surgery, age of patient, gender and other social factors. Nevertheless, experts base their decision to discharge a patient on clinical factors such as patient stability (Berg et al, 2012).

### **Duration of Sick Leave**

This usually refers to the length of time an individual spend at home to fully recover before resuming regular or normal work life. This period also differ between individual and usually influenced by the same factors as discussed above. In general, day surgery patients improve within weeks. However, mastectomy and other more radical surgery patients risk experiencing a protracted post-operative period which if unfavourable, may have a negative impact on the patients.

Following surgery, post-operative recovery is described as the patient's perception of a return to his/her usual self (Kleinbeck, 2000) and as an improvement in functional status (Zalon, 2004). Post-operative recovery is also suggested to be an energy requiring process, as one is returning to the preoperative level of normality and wholeness regarding physical, psychological, social and habitual functions (Berg et al, 2012). Hence, return-to-work (RTW) is a solid post-operative recovery measure following surgery (Kluivers et al, 2008).

Hence, RTW is an essential indicator of post-operative recovery that offer social and economic benefits to the individual and the community through improved quality of life for the individual and improved social participation that benefits the community (Bradshaw et al, 2005), even as various psychological and social factors have been linked with RTW. Such factors include negative emotions and illness related cognitions. Also, studies have established that psychological factors are the most important and decisive factors associated with RTW after a mastectomy (Perk & Alexanderson, 2004; Mital et al, 2004).

## METHODOLOGY

The onus of this study is to investigate how post-surgery self-pity and post-surgery social support relate with post-operatives recovery; hence, the study adopted a correlational research design. A correlational research design is most appropriate where the aim of a research study is to determine the connection between two or more variables (Lomax, 2007). Individuals that have undergone mastectomy constitute the population of the study; while the study utilized data collected from individuals that underwent mastectomy between 2010 and 2013 in the University of Port Harcourt Teaching Hospital. Records of the surgery department of the hospital indicate that the number of persons that underwent mastectomy within the period under focus is eighty-three (83). Data collection was done through a self-made research instrument. The validity of the instrument was confirmed through expert jury opinion consisting of members of the academia and practitioners with adequate knowledge of the subject of the study, while its reliability was confirmed using the Cronbach's Alpha test, with a threshold of 0.70 set by Nunally (1978).

A total of eighty three (83) copies of questionnaire were produced and distributed, however, only seventy seven (77) copies representing ninety-two-point-eight per cent (92.8%) of the printed and distributed questionnaire was used in the final analysis. Data analysis was done using descriptive and inferential statistics while the Pearson product moment correlation was used as the statistic, relying on SPSS version 20.0.

Taking a cue from Agundu and Olotu (2011), the key for interpretation considered appropriate for the correlation ( $r$ ) of study variables was based on the categorizations set by Evans (1996) as follows:

- 0.00 - 0.19 = Very Weak;
- 0.20 - 0.39 = Weak;
- 0.40 - 0.59 = Moderate;
- 0.60 - 0.79 = Strong; and
- 0.80 - 1.0 = Very Strong.

The interpretation process was subject to 0.01 (two tail) level of significance.

## Result

**Table 4: Correlation analysis showing the relationship between post-surgery self-Pity and post-surgery recovery**

Correlations			
Variables	Statistics	Post-surgery Self-pity	Post-surgery Recovery
Post-surgery Self-pity	Pearson Correlation	1	.033
	Sig. (2-tailed)		.778
	N	77	77
Post-surgery Recovery	Pearson Correlation	.033	1
	Sig. (2-tailed)	.778	
	N	77	77

**Source: SPSS output on survey data analysis (2015)**

The information on Table 1 above indicates the result of the test of association between post-surgery self-pity and post-surgery recovery. The  $P(r)$  value of .033 of the result suggests a weak relationship between the variables. Hence, this study accepts the null hypothesis which



states that there is no significant relationship between post-surgery self-pity and post-operative recovery among mastectomy clients.

Based on the  $P_v = .778 > .025$ , the study accepts the null hypothesis. It therefore holds that there is no significant relationship between self-pity and post-operative recovery among mastectomy clients.

**Table 2: Correlation analysis showing the relationship between post-surgery social support and post-surgery recovery**

Correlations			
Variables	Statistics	Post-surgery Social Support	Post-surgery Recovery
Post-surgery Social Support	Pearson Correlation	1	.768 **
	Sig. (2-tailed)		.000
	N	77	77
Post-surgery Recovery	Pearson Correlation	.768 **	1
	Sig. (2-tailed)	.000	
	N	77	77

\*\*. Correlation is significant at the 0.01 level (2-tailed).

**Source: SPSS output on survey data analysis (2015)**

Table 2 displays the result of the test of association between post-surgery social support and post-surgery recovery. The  $P(r)$  produced by the test is .768. This high value suggests that a strong relationship exist between the variables. The positive sign of the correlation coefficient means that the relationship between the variables is a positive one, which implies that the more support the mastectomy client gets from friends and family, the faster the client will recover after the surgical operation.

Based on the  $P_v = .000 > .025$ , the study rejects the null hypothesis and accept the alternate hypothesis. It therefore holds that there is a significant relationship between post-surgery social support and post-operative recovery among mastectomy clients.

## DISCUSSION

### Post-surgery self-pity and post-operative recovery among mastectomy clients

From the result of the current study, it was found that post-surgery self-pity does not support quick recovery of mastectomy clients. This discovery is supported by the fact that self-pity as a coping strategy does not help in strengthening the human immune system. Rather, wallowing in self-pity holds more destructive consequence to the individual; while optimistic expectations are thought to promote confidence and active engagement in the process of adaptation and recovery, while self-pity is known to be destructive (Scheier et al, 1994, 1989)

This finding agrees with the position of Smith and MacKenzie (2006) that self-pity is linked to slower post-operative recovery while Cordova et al (2003) states that self-pity identified among persons that are prone to be affected by stressors and lacks social support. Scheier et al (1994, 1989) suggests that a fighting spirit promotes adjustment to illness and its treatment and that traits of optimism facilitate adjustment to various medical conditions and treatments, including heart surgery.

### Post-surgery social support and post-operative recovery among mastectomy clients

This study found a positive and significant relationship between post-surgery social support and post-operative recovery. This discovery is supported by the fact that social support is correlated with improved emotional stability (House, 1981). During stressful life events when individuals need the assistance of others in the form of social support, which helps in the reduction of anxiety and depression that affects post-operative recovery negatively. Also, Holahan et al (1999), Holahan et al (2000) and Holahan et al (2005) state that social support function as a coping strategy and is known to promote emotional adjustment in chronic conditions like cancer and coronary heart disease, while Cohens and Wills (1985) found that people with low social support report more sub-clinical symptoms of depression and anxiety than do people with high social support.

Effective communication between care givers and clients is also important since effective communication has been found to affect patients' post-operative recovery positively. Agbakwuru (2013) states that the length of period mastectomy clients spends in the hospital may decrease if they are given adequate information about their health and if they are encouraged to express their anxieties freely. Also, empirical findings from the past decades show that clinicians' ability to explain, listen and empathize with their clients have a profound effect on biological and functional health outcome as well as patients' satisfaction which helps speedy recovery (Agbakwuru, 2013). Relatedly, Contrada et al (2004) and McCullough et al (2000) states that religious beliefs and activities may be important for patients confronting life-and-death issues raised by major surgery, suggesting that religious involvement may have possible effects on health outcomes.

## CONCLUSION AND RECOMMENDATION

Based on the empirical tests conducted and the discussions presented in the preceding section, this study concludes that psychological factors interfere with the pace of recovery of mastectomy clients. This conclusion is based on the fact that the empirical tests revealed a weak and insignificant association between post-surgery self-pity and post-operative recovery and a positive and statistically significant association between post-surgery social support and post-operative recovery. The study thus recommends that guidance counsellors and other care givers must ensure that they discourage clients from indulging in self-pity in order to enhance their chances of enjoying quick post-operative recovery. They offer and also solicit the support of friends and families of their clients to assist the clients in every aspect of the post-operative recovery process; as this is found to support quick post-operative recovery.

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