Emotional Vulnerability and the Functional, Social, and Financial Consequences Of Breast Cancer Diagnostic Disclosure: Evidence From A Cross-Sectional Survey of 732 East Algerian Women

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ABSTRACT

Background: Breast cancer diagnosis disclosure entails considerable psychological morbidity and impacts negatively patients' quality of life, functional autonomy and socio-economic conditions. The aim of the current cross-sectional study was to assess the consequences of diagnostic disclosure on emotionality, functionality, socio-economic state and quality of life of patients in the Algerian context.

Methods: We surveyed 732 women who had received a breast cancer diagnosis within the preceding six months. Data collection utilized a comprehensive questionnaire encompassing the Hospital Anxiety and Depression Scale (HADS), the EORTC QLQ-C30 for quality of life evaluation, and open-ended qualitative prompts. Analyses were stratified across emotional, functional, economic, and social parameters.

Results: The cohort exhibited substantial psychological morbidity, with 34% demonstrating severe anxiety and 29% experiencing moderate-to-severe depressive symptoms; nearly half (42%) reported a pervasive sense of isolation. Functionally, 54% struggled with routine occupational or household tasks, while 38% noted impaired mobility. EORTC QLQ-C30 assessments revealed elevated mean scores for fatigue (62/100) and emotional distress (68/100). The socio-economic toxicity was similarly pronounced: 63% of households reported financial hardship, and 51% of patients were forced to scale back or cease professional engagements entirely.

Conclusion: Communicating a breast cancer diagnosis induces severe, multifaceted distress that reverberates across functional, social, and economic domains. These findings underscore the necessity of embedding systematic psychological interventions, robust social support mechanisms, and streamlined care coordination into standard oncological practice.

Keywords: Breast cancer, emotional vulnerability, quality of life, financial toxicity, Algeria, HADS, EORTC QLQ-C30.

INTRODUCTION

In Algeria, breast cancer remains the predominant malignancy affecting women, constituting a critical public health concern. The initial disclosure of the diagnosis frequently acts as a catalyst for intense emotional vulnerability, characterized by acute anxiety, depressive episodes, and profound feelings of seclusion. Beyond the immediate psychological toll, this phase is typically associated with a cascading deterioration in quality of life, diminished functional autonomy, and a substantial socio-economic burden borne by both patients and their families.

Notwithstanding the high prevalence of this pathology, localized research examining the multidimensional fallout of diagnostic disclosure in Algeria remains sparse. The present cross-sectional investigation endeavors to address this literature gap by critically assessing four primary domains: (1) immediate emotional distress, (2) disruptions to daily functional capacity, (3) perceived quality of life, and (4) the socio-economic constraints imposed by the disease.

METHODOLOGY

2.1. Study Population The study cohort comprised 732 women, aged 32 to 70, who had been diagnosed with breast cancer within the six months preceding the survey. To ensure a diverse and representative sample, recruitment was executed across oncology outpatient departments, patient advocacy networks, and targeted online support platforms.

2.2. Data Collection Tools Data were compiled via a multifaceted instrument battery. A sociodemographic profile captured age, marital status, educational attainment, household income, and employment status. Psychometric evaluation was conducted using the HADS to quantify anxiety and depression, alongside the EORTC QLQ-C30 instrument to gauge quality of life metrics. Additionally, open-ended queries were integrated to elicit patient narratives regarding unmet clinical needs and potential systemic improvements.

2.3. Data Analysis Quantitative variables were processed via SPSS software, utilizing descriptive statistics and cross-tabulation to identify demographic trends and correlations. Concurrently, qualitative responses from the open-ended section underwent manual thematic coding to extract recurring patient sentiments.

RESULTS

3.1. Sociodemographic Profile The demographic breakdown of the cohort is detailed in Table 1. The mean age of the participants was 51 years (SD: 9). The majority of respondents were married (62%) and had attained at least a secondary level of education (72%). Regarding employment, 38% were actively working at the time of the survey, while 33% were on medical leave. Income distribution indicated that 42% of the cohort earned between 30,000 and 60,000 DZD monthly, with 38% earning below the 30,000 DZD threshold.

Table 1: Sociodemographic Characteristics of the Study Cohort (N=732)

Variable	**Category**	**Frequency (%)**
Age (years)	Mean ± SD	51 ± 9
Marital Status	Married	62%
Single	22%	
Divorced	11%	
Widowed	5%	
Education Level	Primary	28%
Secondary	43%	
University	29%	
Professional Status	Employed	38%
On sick leave	33%	
Retired	29%	
Monthly Income (DZD)	< 30,000	38%
	30,000 – 60,000	42%
	> 60,000	20%

3.2. Emotional and Psychological Impact Psychometric evaluation via HADS yielded concerning markers of psychological morbidity (Table 2). Over a third of the cohort (34%) exhibited severe anxiety, and 29% presented with moderate-to-severe depression. Furthermore, 42% endorsed a distressing sense of isolation. Crucially, access to dedicated psychological support was lacking for 69% of the participants.

Table 2: Psychological Morbidity and Emotional Distress Post-Disclosure

Indicator	**Prevalence (%)**
Severe anxiety (HADS)	34%
Moderate-to-severe depression (HADS)	29%

Reported sense of isolation	42%
Access to psychological support	
Yes	31%
No	69%

3.3. Impact on Functional Capacity The functional decline associated with recent diagnosis was significant, as summarized in Table 3. More than half of the surveyed women (54%) reported significant difficulty executing occupational or household tasks. Basic daily activities, such as dressing and personal hygiene, posed challenges for 48% of the cohort, while 38% experienced restricted mobility affecting their ability to shop or utilize transportation.

Table 3: Impairment in Functional Capacity

Activity	% of Women Reporting Difficulties
Work or household tasks	54%
Daily activities (dressing, hygiene)	48%
Mobility (shopping, transportation)	38%

3.4. Quality of Life Assessment (EORTC QLQ-C30) Quality of life metrics (Table 4) highlighted a severe symptom burden. Mean scores peaked in emotional difficulties (68/100) and fatigue (62/100). Sleep disturbances (insomnia) were reported with a mean score of 55/100, followed by pain at 45/100.

Table 4: EORTC QLQ-C30 Quality of Life Mean Scores

Symptom / Domain	Mean Score (0–100)
Emotional difficulties	68
Fatigue	62
Insomnia	55
Pain	45

3.5. Economic and Social Burden The financial toxicity of the diagnosis was pronounced (Table 5). A majority of households (63%) reported a direct economic impact due to the illness. Consequently, 51% of patients were compelled to reduce or entirely cease their professional activities. While 48% reported strong familial support, only a marginal 22% benefited from external assistance programs.

Table 5: Socio-economic Burden and Support Systems

Theme	Response Distribution
Financial impact on household	Yes: 63% / No: 37%
Reduction or cessation of work	Yes: 51% / No: 49%
Family support	Strong: 48% / Moderate: 32% / Weak: 20%
External assistance received	Yes: 22% / No: 78%

3.6. Qualitative Analysis Thematic analysis of patient narratives underscored critical gaps in care infrastructure and support. Representative verbatims included: “I would have appreciated more attentive listening right after the diagnosis.” “There is a lack of psychologists in hospitals.” “Transportation costs for chemotherapy are very high.”

DISCUSSION

The disclosure of a breast cancer diagnosis represents a profound biopsychosocial shock. Our data indicate that over a third of Algerian women experience severe anxiety, a prevalence exacerbated by a stark deficit in accessible psychological care. The functional decline and severe financial toxicity reported—likely compounded by out-of-pocket costs for treatment logistics—mirror patterns observed in low-to-middle-income oncology settings.

The qualitative narratives particularly highlight a fragmented care continuum, where patients feel emotionally abandoned post-diagnosis. Consequently, there is an urgent imperative to transition from a purely biomedical oncology model to a holistic biopsychosocial framework. This requires not only embedding psychological services within oncology wards but also establishing structural financial buffers and enhanced multidisciplinary care coordination.

RECOMMENDATIONS

Based on these empirical findings, we propose several targeted interventions:

- **Clinical Practice:** Mandate communication skills training for oncology practitioners to optimize disclosure protocols, ensuring the immediate availability of a clinical psychologist post-diagnosis.
- **Social Welfare:** Institute targeted financial assistance programs to subsidize transportation and treatment costs for low-income demographics.
- **Community & Peer Support:** Foster collaborative networks with patient associations to expand peer-led accompaniment programs.
- **Health Policy:** Broaden the scope of social coverage to comprehensively encompass the indirect costs associated with oncological care.

CONCLUSION

This investigation elucidates the pervasive, multidimensional impact of breast cancer diagnostic disclosure in Algeria. To meaningfully improve patient trajectories, oncological care must evolve beyond tumor management to embrace a holistic paradigm—one that equally prioritizes psychological resilience, socio-economic mitigation, and integrated care coordination.

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