image) are collected before pathologic confirmation and announcement of the treatment plan. The data relative to the coping strategies (perceived stress, controlability, social support, coping) are evaluated few days after diagnosis confirmation. A principal component analysis followed by varimax rotations shows four coping strategies. Two are active: problem solving and social support satisfaction and the others are passive: guilt with avoidance, helplessness-distress. The regression analysis shows: age is associated with the problem solving strategy, high trait anxiety, children's poor health and patient's poor health are significatively predictive of the use of guilt and avoidance strategy ($p < 0.05$). The use of helplessness-distress strategy is very significantly associated with an unfavorable body perception and with young age ($p < 0.01$). The results also show that the absence of psychological problems such as depression and nevrose, a high number of life events and young age predict significantly social support satisfaction ($p < 0.05$).

PP-10-4 Breast Care Nursing Intervention Survey

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A survey of 99 patients was carried out to seek patients views on the timing of intervention and the type of information they needed between diagnosis and hospitalization. 83% response rate: average age 58.41 years.

95% wanted information on treatment options, possibility of recurrence, radiotherapy, prosthesis, post-operative exercises and reconstruction.

54% wanted intervention for up to 8 weeks, 18% for up to 6 months.

This kind of survey would enable the breast care nursing service to respond to the needs of all women with breast cancer, not just those who suffer psychological morbidity.

PP-10-5 Involving a Trained Psychologists at the Time of Breast Cancer (BC) Surgery: Effects on Communication and Psychosocial Adjustment

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This study examines how BC patients rate psychosocial support and medical information received from health professionals in a single senology unit which includes a trained psychologist. In addition to conventional medical care, all BC patients in our unit meet with the clinical psychologist at least three times during their hospital stay. *Methods:* Opinion was seeked by means of questionnaire from 98 consecutive BC patients, 6 months after discharge from hospitalization for BC surgery. All patients were considered to have operable disease at the time of diagnosis. Specific questions were asked about the level of satisfaction with medical information and psychological support received during and after hospitalization. *Results:* The response rate was high (71 patients, i.e., 72%). Forty-one patients had undergone a modified radical mastectomy and 30, a lumpectomy with auxiliary dissection. Tumors were rated as Tis (6%), T1 (37%), T2 (48%), T3 (6%), or T4 (4%). Nodes were negative in 72% and positive in 28%. A vast majority of women (97.2%) expressed satisfaction about the amount and quality of medical information received at the time of diagnosis; 91.4% were also satisfied with the empathy they had perceived in their physician. However, the percentage of patients who remained satisfied with the medical information they were given during the 6 months of follow-up dropped to 67.1%. A parallel should be drawn with the fact that during hospitalization BC patients addressed 84% of their medical questions to the medical team, whereas before and after hospitalization they addressed respectively only 65% and 76% of their questions to the medical team. Sixty-five percent of women reported they had been effectively supported by their meetings with the psychologist, whereas 11.3% thought they had received insufficient psychological support at the time of surgery. Specifically, 69% of BC patients estimated that an early psychological support is useful. *Conclusion:* These data confirm the necessity to provide BC patients with continuous medical support and information, especially during the critical periods before and after hospitalization for surgery. Psychological support.