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Coping with loss of ability vs. emotional control and self-esteem in women after mastectomy

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ABSTRACT

Aim: Does coping with the loss of ability depend on self-esteem and emotional control?
Background: Persons who experience losses in two dimensions, i.e. health and ability can deal with the loss by physical therapy, and also by mental and socio-professional rehabilitation. But far and foremost, it is the personality of the person who experiences the loss that matters most.
Materials and methods: The study included 37 patients after mastectomy. They were divided into two groups according to the time elapsed from cancer diagnosis. The study was conducted using the Questionnaire on Coping With Ability Loss (P. Wolski), Self-Esteem Loss (M. Rosenberg,) and the Courtauld Emotional Control Scale – CECS.
Results: In Group I, the higher level of acceptance in the QCAL test, the higher self-esteem. The more depression experienced by individuals, the lower is their level of self-esteem or the less depression experienced, the higher the self-esteem. In Group II, the higher the level of depression, the lower the level of anger. The greater the struggle, the lower level of anger. The lower the level of depression and struggle, the higher the level of emotion control.
Conclusions: Women diagnosed no longer than five years back do not differ from those diagnosed further back in terms of copying with the loss of ability, self-esteem and emotional control.

1. Background

Diagnosis of cancer, such as breast cancer, and a prolonged and strenuous treatment that follows are critical experiences in everybody's life. The crisis may get even worse if cancer treatment – e.g. surgery – results in acquired disability. Both cancer diagnosis and acquired disability affect all aspects of the patient's life. They lead to changes in self-image, emotional response and actions driven by it, interpersonal relations and system of values. Disintegration may be said to occur at all levels: cognitive, emotional, behavioural, social

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and spiritual. Disintegration of one's identity due to the disease and its effects and re-consolidation are of a processual nature (and have been discussed by many researchers[1]: Freud, 1917/1958; Kubler-Ross, 1969; Bowlby and Parker, 1970; Engel, 1974; Kerr 1977, Cogswell 1984, Krueger 1984, Pulton 1984, Elbirlik 1985, Livneh and Antonak, 2005, Wolski, 2010).[2–7] The objective that should be pursued by both the above mentioned sinusoidal and sequential processes is patient's return to their everyday satisfactory psychosocial functioning. To achieve that goal, a thought should be given to what conditions should be met to enable an adequate and effective rehabilitation, not just curative but also mental and socio-professional. However, to answer that question, one should begin with defining the concept of disability. Many attempts have been made to create one adequate definition accommodating the multivariate nature of that concept: beginning with the one proposed by the World Health Organisation (WHO) through the that adopted by the Polish Central Statistical Office GUS (1997) or the UN General Assembly (2006), the definitions included in the Chart of Rights for Persons with Disabilities (1997), Act on Professional and Social Rehabilitation and Employment of Disabled Persons, Pension and retirement Act (Social Security Fund), to definitions developed for scientific and scholarly purposes: Weiss,[8] Hanselmann,[9] Zabłocki.[10]

Since the 1990s, a new trend has emerged in defining and diagnosing disability. Up to then, a biological model had been used with dysfunction of the body considered mainly in the context of employment.[11,12] The understanding of disability has evolved, however, into an interactive (social) model which regards limited ability to be an effect of physical, economic or social obstacles existing in the environment of a person with a congenital or acquired disability.[13]

2. Aim

A practical question to be asked in the context of the social model is how a person experiencing losses in two dimensions, i.e. health and ability,[14] can deal with the loss? Certainly, as mentioned before, physical therapy is helpful in that process, but so is also mental or socio-professional rehabilitation. But far and foremost, it is the personality of the person who experiences the loss that matters most.[15,16] Does coping with the loss of ability depend, then, on self-esteem and emotional control? The answer will help recognise which aspects of mental rehabilitation should be focused in particular.

3. Materials and methods

The study included 37 patients with history of breast cancer, aged 52–74. They were divided into two groups according to the time elapsed from cancer diagnosis (group I: up to five years from diagnosis: $n = 18$, group II: more than five years from diagnosis $n = 19$; cancer patients perceive the first five years of remission as a critical period with the highest risk of relapse). All the subjects had undergone mastectomy. Due to the surgery, they became disabled (according to the above mentioned biological model).[11–13] The study is of a practical type.

The study was conducted using the Questionnaire on Coping With Ability Loss (P. Wolski), Self-Esteem Loss (developed by M. Rosenberg, adapted by: I. Dzwonkowska, K. Lachowicz-Tabaczek, M. Łaguna) and the Courtauld Emotional Control Scale – CECS (M. Watson, S. Greer, adapted by Z. Juczyński).

The Questionnaire on Coping With Ability Loss – QCAL (developed by P. Wolski) is designed to diagnose the stage of coping with the loss of ability. The questionnaire comprises 27 items divided into three scales: Struggle (combing three sub-scales: shock and denial – 4 items; anger – 3 items, bargaining – 8 items); Depression – 4 items; Acceptance – 8 items. Scores obtained are entered by the investigator into an Excel worksheet template in a 0/1 system where 0 stands for 'no' and 1 for 'yes' with regard to particular statements. The assessment of scores is based on the median of each of the five sub-scales corresponding to three stages of coping with the loss. Five scores are calculated – separately for each sub-scale. Results of the first three sub-scales sum up to make the score of the struggle scale. Scores above the median for a specific scale indicate at what stage the patient is, while scores below the median imply that the stage lacks any characteristic features. High scores are also assumed for neighbouring phases as a manifestation of the so called interphase transition. It is assumed that identification of the stage of coping with the loss of ability allows to predict an individual's behaviour, being representative for that particular stage.[16–18]

Self-Esteem Scale – SES (developed by M. Rosenberg, adapted by: I. Dzwonkowska, K. Lachowicz-Tabaczek, M. Łaguna) is a one-dimensional tool to assess a general level of self-esteem or a permanent predisposition understood as a conscious attitude (positive or negative) towards the self. It consists of ten diagnostic statements. Respondents are asked to show in a four-level scale to what extent they agree with each of the statements, scoring 10–40 points, where fewer points indicate a higher self-esteem. Individuals with a high sense of self-esteem are aware of their capabilities and deficiencies and accept themselves as they are while feeling the need to develop and overcome their weaknesses. Individuals with a low sense of self-esteem (high scorers) are characterised by low levels of self-satisfaction, self-acceptance and self-respect, and consequent lack of motivation to develop and overcome their weaknesses.[19]

Courtauld Emotional Control Scale – CECS (developed by M. Watson, S. Greer, adapted by: Z. Juczyński) is a tool consisting of three sub-scales each containing seven statements regarding the way of expressing anger, anxiety and depression. The score range for each of the three sub-scales is 7–28 points. By summing up the scores of the sub-scales, we determined *the general emotional control*, meaning the individual's self-reported ability to control her reactions when experiencing certain difficult emotions. *The general emotional control* falls within the 21–84 score range. The higher the score, the more suppressed the emotions are. Most statements refer to specific forms of emotional suppression. The scale is used for measuring self-reported control of anger, anxiety and depression in difficult situations and is designed to investigate adults, both healthy and diseased.[20]