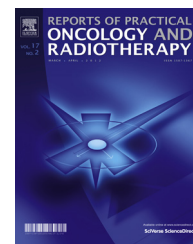


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Original research article

Coping with loss of ability vs. acceptance of disease in women after breast cancer treatment

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ABSTRACT

Aim: To answer the question: is there a correlation between coping with the loss of ability and the acceptance of disease?

Background: The loss of ability is the beginning of a process of dealing with a widely understood dysfunction and its consequences. This happens owing to the lifting of the barriers that emerged due to the loss of ability and through the acquisition of skills that help an individual find their way in the new reality.

Materials and methods: The study included 90 patients with history of breast cancer. They were divided into two groups- I: up to five years from diagnosis, II: more than five years from diagnosis. The study was conducted using the Questionnaire on Coping With Ability Loss by P. Wolski, Acceptance of Illness Scale – B.J. Felton, T.A. Revenson, G.A. Hinrichsen, adapted by: Z. Juczyński.

Results: Group I: it is positive weak correlation, meaning that the higher level of acceptance in the QCAL test, the higher acceptance of illness. Group II: there is no relation between acceptance of illness and the QCAL test acceptance scale and no relation between depression and the level of acceptance.

Conclusions: The more depressed a patient is and the less successful they are in dealing with the loss of ability, the lower their level of acceptance of illness. On the other hand, in time, it is struggle with the disability that plays more important role in the acceptance of the disease than the impact of negative emotions.

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1. Background

Any disease, particularly a chronic one like breast cancer, is a critical situation. The diagnosis phase, the chronic phase and the terminal phase all bring a whole spectrum of dynamic

and extreme emotions that disintegrate all areas of the life of a person diagnosed with cancer: physical, mental, social and spiritual. Strong emotional reactions combined reinforced with close and remote effects of treatment often give rise to adaptive disorders which may impede patient's return to a satisfactory every day psychosocial functioning.

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One of possible side effects of breast cancer treatment is acquired post-surgery disability (lymphadenectomy). The loss of ability and diagnosis of cancer are breakthrough events.¹

There are plenty of concepts and models that try to define disability.² Since the 1990s, a new stage began in defining and diagnosing the loss of ability. The first, biological model was primarily based on the understanding of bodily dysfunction in the context of employment.^{3,4} Then, an interactive (social) model developed and still applies regarding the limitation of ability as an effect of physical, economic or social barriers in the disabled person's life.⁵

The loss of ability is the beginning of a process of dealing with a widely understood dysfunction and its consequences.⁶ The process leads to the transformation of self and one's functioning in various areas of life. This happens owing to the lifting of the barriers that emerged due to the loss of ability and through the acquisition of skills that help an individual find their way in the new reality.⁷ Many authors have developed concepts regarding the course of the process.^{4,6,8–13}

2. Aim

Despite the similarity between the effects of both critical events, i.e. diagnosis of breast cancer and the loss of ability (disintegration in all areas of human functioning: cognitive, emotional, behavioural, social and spiritual, decomposition and integration of identity and associated disorders,¹⁴ mental suffering incurred), is there a correlation between coping with the loss of ability and the acceptance of disease? Is there a relationship between the stage of coping with the loss of ability and the level of adaptation to the disease? Answers to these questions may provide a practical diagnostic and therapeutic guidance to professionals who work with cancer patients (at various stages of treatment).

3. Material and methods

The study included 90 patients with history of breast cancer, aged between 36 and 82 years. They were divided into two groups according to the time elapsed from cancer diagnosis. Group I: up to five years from diagnosis: $n = 71$ (36 subjects after mastectomy, 35 – after quadrantectomy; 7 premenopausal, 12 perimenopausal, 49 postmenopausal women). Group II: more than five years from diagnosis $n = 19$ (10 subjects after mastectomy, 9 – after quadrantectomy; 3 premenopausal, 5 perimenopausal, 11 postmenopausal women). All the subjects from both groups had undergone lymphadenectomy. Cancer patients perceive the first five years of remission as a critical period with the highest risk of relapse. Due to the surgery, they became disabled (according to the biological model).^{3–5} The study is of a practical type.

The study was conducted using the Questionnaire on Coping With Ability Loss, developed by P. Wolski, Acceptance of Illness Scale – AIS, developed by B.J. Felton, T.A. Revenson, G.A. Hinrichsen and adapted by Z. Juczyński.

The Questionnaire on Coping With Ability Loss – QCAL is designed to diagnose the stage of coping with the loss of ability. The questionnaire comprises 27 items divided into three scales: struggle (combining 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 person 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 inter-phase 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.^{15–17}

Acceptance of Illness Scale – AIS is a tool to measure the degree of acceptance of the disease; it consists of eight statements describing adverse consequences of poor health. Those consequences amount to the recognition of the limitations imposed by the disease, lack of independence, sense of dependence on others and reduced self-esteem. Full agreement (marked 1) expresses poor adaptation to the disease, while full disagreement (marked 5) means the acceptance of the disease. The total of all scores is, therefore, an overall measure of the acceptance degree, ranging from 8 to 40 points. A low score represents the lack of acceptance of and adaptation to the disease and a strong sense of mental discomfort. A high score, on the other hand, reflects the acceptance of one's disease that is manifested with the absence of difficult emotions related to it. The acceptance of the disease is demonstrated by lower intensity of adverse reactions and emotions associated with that disease. The scale may be applied to assess the degree of acceptance of any disease. It is used for investigating adult patients who are currently affected by the disease.¹⁸

4. Results

Research problem 1: Is coping with the loss of ability linked with the acceptance of the disease in women after cancer treatment?

Operationalisation of variables:

- Coping with the loss of ability – the measurement of the variable was made using the Questionnaire on Coping with Loss of Ability (QCAL). The variable was described by three scales in the questionnaire: struggle, depression and acceptance.
- Acceptance of illness – the measurement was taken using the Acceptance of Illness Scale (AIS). The variable is measured by one scale in the questionnaire.
- Women after breast cancer treatment – the study sample was split into two groups; the first one was made up by women who were diagnosed within recent 5 years (not earlier than in 2010), and the other one consisted of women who were diagnosed longer than 5 years ago.

Statistical description of the variables is shown in [Table 1](#).

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