

Alicja Keplinger¹

Department of Psychology, Wroclaw University, Poland

Dorota Dominiczak

Amoena Polska Sp. z o.o.

Psychological gender and quality of life of women who have experienced mastectomy.

Abstract

The purpose of this article is to present the results of a correlational study on the relationship between three elements: psychological gender, quality of life and mastectomy. The research question was formulated as follows: “Do women of different psychological genders who have undergone mastectomies differ in their way of sensing their quality of life?” Results are based on our own empirical research on a group of 70 women between the ages of 41 and 72. In the past all of these women underwent mastectomies. Results reveal that in comparison with other persons surveyed, androgynous women may have a higher level of satisfaction and sense of ability/productivity in dealing with this disease. Interestingly, so-called “masculine women” do not appear within the researched persons’ gender identity types. Perhaps the breast cancer experience has caused a distinct focus on not only physical but also psychological, namely identity related, femininity attributes, contributing to identity-related compensation of one’s own femininity. The obtained results are a strong inspiration for further research.

¹ Alicja Keplinger, Department of Psychology, Faculty of Pedagogical and Historical Sciences, University of Wroclaw, Dawida 1, 50-527 Wroclaw, Wroclaw University
a.keplinger@psychologia.uni.wroc.pl
Dorota Dominiczak, Amoena Polska Sp. z o.o.
dordom@wp.pl

Introduction

Each year over 10 000 Polish women fall ill with breast cancer. Tumor spoils one's plans, shatters hopes and dreams, and ruins careers. It turns out that breast cancer is a taboo subject and persons afflicted with the disease try to hide it for fear of losing a job or of acquaintances' reactions. Moreover, women diagnosed with breast cancer are deeply afraid of being rejected by their husband or other relatives and have to deal with the fear of death. In order to fully return to everyday life after a mastectomy, a woman has to reconstruct her sense of identity, self-confidence and also has to accept her femininity with her cancer experience. In Poland, cancer is the leading cause of death. Each year more than 10 000 new cases of breast cancer are diagnosed, which is the highest percentage of all tumors affecting women.

Tumor – is a word which always terrifies, yet it is breast cancer that causes particular concern². Hence, a sick woman delays an appointment with a doctor for fear of mutilation since for a woman breasts have, among other things, emotional significance; they are a symbol of maternity, femininity and sexual attractiveness. Nowadays, breasts as an attribute of femininity are displayed everywhere: in commercials, films, and magazines. The media set the tone for socially accepted “cults”, but undoubtedly they also reflect some so-called “common street” values. The cult of the body, so glorified today, gives women's breasts particular importance, which surely does not make it easier for women after mastectomies to cope with breast loss, even if the reason for amputation was saving life and health. It is a fact that breast cancer disrupts the balance of femininity as it is very hard to come to terms with the loss of breasts which in the face of the disease become a more distinct feminine attribute, an attribute of psychological gender identity, and an attribute of health which one has lost. According to E. J. Taylor (Jaśkiewicz 2005) such a traumatic experience as a tumor must be followed by changes in one's attitude towards life. Among the most important changes, the author numbers changes in life's priorities and in its values which rest on appreciating the significance of close bonds with friends and family, and developing greater sensitivity to another human being and his needs. Once, during research, a patient with advanced breast cancer said, “...The illness has made me a better person. I've become more aware of other people and their needs.” Crisis events may have a positive value. Despite the magnitude of such a disaster, one gets the opportunity to reflect on life, to build up better relationships with people, and to distance oneself from the everyday pursuit of money, fame and success.³ Work

² Baum M., Saunders Ch., Meredith S., *Breast Cancer*, Warszawa: PWN, p. 10.

³ Jaśkiewicz M., 2005, *Rising from crisis. Breast Cancer* ,, Charaktery, 3, 10- 13.

in the field of preventive medicine shall require a knowledge of psychological gender-identity types and ways of building up one's quality of life. The purpose of this article is to present the results of a correlational study on the relationship between three elements: psychological gender identity, quality of life and mastectomy. It is assumed that gender identity is a crucial determinant of quality of life and may either positively or negatively contribute to the process of dealing with illness and accepting one's body after a mastectomy. What type of gender identity are such women who, despite this illness, live life to the fullest, work, do not resign from active living, develop themselves, care about health and physical appearance, have a social life, involve themselves in the social battle with breast cancer and help other persons with this problem?

Gender – the cultural perspective.

Sex is the first visible human characteristic. People assign to men and women different attributes. The axiological aspects of social signaling⁴ is connected with the type of gender culture. Thus, in so-called masculine culture the masculine stereotyping are the following: career, competition, assertiveness, aggressive behaviors, whereas in feminine culture there are cooperation, gentleness, taking care of human relations and family. In the masculine culture money is important and a man is expected to be ambitious, assertive, stress-resistant, strong and tough; he is also responsible for supporting his family. In feminine culture valuable are affection, warmth, and taking care of the home and other people. Upbringing depends on a child's gender. Differences in the approach to boys and girls are visible as early as in childhood. According to stereotypical ideas of what may a given sex needs, parents arrange different rooms for a boy and a girl, they also buy different toys for them. Boys will be more physically stimulated, and will be encouraged to crawl and walk. Girls will be stimulated more verbally, and will be encouraged to smile and talk. Girls are allowed to express their feelings, for example to cry, laugh and so on. Boys mustn't cry, and are allowed to behave bravely especially when they need to defend themselves. Fathers get more involved in motor activities rather with their sons than with daughters, while mothers prefer symbolic games and activities to which they encourage daughters rather than sons. Parents reinforce obedient behavior in daughters and emphasize assertiveness and independence in sons. In masculine culture being the best student is highly appreciated; therefore, failure in school is treated as a defeat. In feminine culture school failure is not perceived as a fiasco, since cooperation is more important than competition. In

⁴ This may not be the right word. Stigmatize means to disgrace. This statement and the following ones would be speaking about disgraceful masculine and feminine traits.

masculine culture people are expected to preserve the attributes of femininity or masculinity in behavior as well as in thinking and physical appearance. For a man work is a symbol of power, a source of authority; it is something to which a man can devote himself. A woman hardly ever sacrifices personal life for work – for her the most important is the family. For a man to be loved means to be admired, whereas a woman needs proof of love, understanding and nice gestures.⁵ Psychologist Alicja Kuczyńska (1992) in researching gender stereotypes and the identity of psychological gender analyzes what stereotypes of femininity and masculinity function in Polish society. According to her, stereotypically recognized masculine characteristics are the following: they need to be dominant, independent, competitive, combative, success-driven, easily making decisions, coarse, arrogant, be in good physical condition, have a sense of humor, be persuasive, self-confident, self-sufficient, non-emotional, comfort-loving, open to the world of external events, experimenting in sex life, and clever. While the characteristics of women and femininity are defined as sensitive, caring, loving, engaging in the affairs of others, gentle, flirtatious, caring about appearance, thrifty, having a sense of aesthetics, grumpy, emotional, sensitive to the needs of others, able to make sacrifices, reflective, fragile, bashful, and naive.⁶

Although we usually do not realize it, we all use stereotypes. They are a kind of mental shortcut which help us to make a quicker judgment about another person or persons without actually knowing them. “Stereotypes help us to predict how particular persons may behave and what would be the best way of dealing with them.”⁷ Our research reveals that each human being has developed a specific gender stereotype. “The extensive body of empirical research suggests the significant influence of psychological gender on individuals’ functioning, opportunities for their development and constructive action. The empirical data also show that taking into consideration psychological gender allows for a broader and more diversified analysis of the human psyche and behavior.”⁸ It is assumed that knowing the psychological differences of gender identity helps one understand why some women are able to easily regain their balance after cancer while others need much more time. For many years now the psychological gender of a human being has been the subject of research. One of the forerunners in this field is Sandra L. Bem, who developed four main configurations of psychological characteristics:

⁵ J. Miluska. *The Gender of Culture, Charaktery*, August 2002 p. 62-64.

⁶ M. Oleś, S. Steuden, P. Klonowski et al.; *The Methods of Investigating the Quality of Life*. W: (ed.) M.Oleś, S. Steuden, J. Toczolowski ; *How Little of the World I See. The quality of life perception disorders.*, Lublin, 2002, Wyd. TN KUL, p. 52-53.

⁷ A. H. Eagly, L.L.Carli, *Women...*, p. 130.

⁸ A. Kuczyńska, 1992, *An inventory of Psychological Gender*, Warszawa: Polskie Towarzystwo Psychologiczne, p. 5.

- sex-typed persons – individuals whose psychological gender matches their physical sex (feminine women and masculine men)
- androgynous persons – individuals who possess both masculine and feminine traits, regardless of their biological sex
- undifferentiated persons – individuals who have low identification with either feminine or masculine characteristics, regardless of their biological sex
- cross-sex-typed or sex-reversed persons – individuals whose psychological gender is the opposite of their physical sex (feminine men and masculine women)⁹

In the context of social attractiveness, the androgynous type is the most desired, which according to S.L. Bem (Kuczyńska, 1992) has greater opportunities for constructive action, is not influenced by social pressure, has high self-esteem and can more easily adjust to different situations. An androgynous individual may also be characterized as a flexible, stress-resistant person with a strong personality and good health. Persons who identify themselves with their physical sex in typical ways within the context of cultural conditions are not able, according to Sandra Bem, to increase their potential beyond the frames of existing femininity or masculinity stereotypes, which in the face of illness and mastectomy may appear to limit treatment and recovery and to hamper adjustment to the new, difficult situation connected with a change of physical appearance.

Sense of quality of life

Formerly grounded in philosophy, psychology pondered questions about the source of happiness and suffering, and about how positive or negative life experiences entered into them. The dynamic development of research on the above-mentioned issue and the knowledge gathered allowed one to distinguish the new, relatively independent field of psychology – the psychology of quality of life (Grinde, 2002).

The multitude of interpretations of quality of life may be presented in a certain order (Bowling, Flynn 2004 in: M. Oleś 2010, p. 38-39) according to the models distinguished below:

1. Models based on objective indicators – health standard, life span, living standards and costs, independence etc.
2. Models based on subjective indicators – such as life satisfaction and mental wellbeing, morality, self-realization, happiness, self-esteem etc.
3. Models emphasizing satisfaction from fulfillment of one's needs.

⁹ Kuczyńska A. , 1992, *An inventory of Psychological Gender*, Warszawa: Polskie Towarzystwo Psychologiczne, p. 5.

4. Psychological models describing human functioning as a whole – including, for instance, personal development, cognitive competence, effectiveness, independence, and sense of dignity¹⁰.
5. Social models, also called social health models, include such indicators as social networking, support, commitment and social integration.
6. Health models – with emphasis on an individual's functioning – are based on the measurement of one's state of health or the functioning of health care.
7. Models of social cohesion and social capital – including social resources, for instance, interpersonal relations, and environmental resources such as access to goods and to a flat
8. Environmental models – accentuate factors directly connected with living conditions and social politics with emphasis on promoting a healthy life style .
9. Idiographic, individualized models – constitute a hermeneutic approach based on an individual's values and system of meanings, and on the individual's perception of satisfaction.

The multitude of interpretations of quality of life reveals some regularity. Firstly, it shows that there is a passage from defining quality of life in objective categories into interpreting it based on subjective indicators; and secondly, the range of understanding quality of life increases so that more and more spheres of life and psychological variables are included in the concept. Thirdly, there is consistent departure from such interpretations which emphasize deficiencies in quality of life, for example during a neoplastic disease, and a tendency towards those which focus on positive phenomena, for example on health or on opportunities for comprehensive development.

The World Health Organization defines quality of life as an “individual's perception of their position in life in the context of the culture and value system in which they live and in relation to their goals, expectations, standards and interests.” Quality of life is good when individual expectations match reality. “Quality of life is always a subjective value and to a great extent depends on an individual's frame of mind, personality traits, their likes and value system” (De Walden-Gałuszko 1997).

Quality of life is a notion that needs to be understood holistically, as it goes beyond the dimensions of health. Schalock's and Straś-Romanowska's concepts meet the criteria of a holistic approach because they refer to different spheres of human life.

The personalistic-existential conception of quality of life described by Maria Straś-Romanowska (1992, 2003, 2005) assumes that mental life has four dimen-

¹⁰ “For instance” and “etc.” contradict each other.

sions: 1. psychophysical, 2. psychosocial, 3. subjective, and 4. metaphysical/existential. By adopting these assumptions, quality of life may be defined generally as a way of living, that is, a way of dealing with different kinds of problems typical of each dimension. What is important from a psychological perspective is the subjective evaluation of how one lives with his/her accompanying feelings – as these feelings constitute the sense of quality of life.

In order to evaluate the sense of life quality, the Sense of the Quality of Life Questionnaire for adults by R. Schalock and K. Keith modified by Maria Oleś (translated into Polish by Andrzej Juros) has been applied. The authors of R. Schalock's and K. Keith's method (cf. M. Oleś, S. Steuden and others, 2002, p. 53) point out that a human being in order to say that he is satisfied with the actually high level of quality of his life has to achieve fulfillment in five areas :

- satisfaction
- ability / productivity
- ability to act / independence
- social affiliation / integration
- health (quality of life during illness)

The satisfaction area pertains to feeling content with one's current home and life situation, with having achieved success and financial status, feeling mentally comfortable in social situations, and feeling a sense of importance with family affiliations and encountered life problems. The ability / productivity area includes the individuals' sense of satisfaction with their competence and opportunity for enhancing skills, their independence, and with the way they are treated by others. The third field – ability to act / independence – refers to sense of independence and autonomy in everyday life. The fourth area – social affiliation / integration with community – includes the individuals' sense of belonging to some community and actively participating in social life. The final and fifth area is connected with health (quality of life during illness). It concerns the influence of illness and ailments upon a person's life and performance of everyday activities, and includes an evaluation of seeing one's ability and sense of quality of interpersonal relations during a sickness.

A man evaluates his life situation and quality of life by very often comparing his standards and values to some other person's life situation. This evaluation can be made objectively or subjectively, from the position either of an observer or an actor. As instances, a doctor will focus on the psychophysical aspects of health and disease. A person who suffers from illness will make a subjective evaluation of his/her quality of life. In tumor diseases the quality of life evaluation fluctuates and depends on the amount of lapsed time since the disease was diagnosed or, in the case of women diagnosed with breast cancer, from the operation. Women have difficulties accepting mutilation. There are cases, especially in the first period fol-

lowing an operation, that women don't want to look at themselves in the mirror; they withdraw from intimacy with their husband, look at other women with fear or even contempt, and grapple with the question of why it happened to them. Psychiatric everyday practice with cooperating women after mastectomies is a source of interesting observations. Breast amputation causes extremely difficult psychological situations in all four dimensions: 1. psychophysical, 2. psychosocial, 3. subjective, 4. metaphysical/existential. The type of psychological gender identity is a significant predictor in dealing with the stressful process of recovery and caring about quality of life in every one of the above-mentioned dimensions.

Research procedure and analysis of results

In order to answer the research question, two questionnaires were used. Psychological gender was diagnosed with The Inventory of Psychological Gender by A. Kuczyńska (1992) which enables one to define the type of psychological gender: 1) sex-typed persons – individuals whose psychological gender matches their physical sex, that is, feminine women and masculine men, 2) androgynous persons – individuals who possess both masculine and feminine traits, 3) undifferentiated persons – individuals who have low identification with either feminine or masculine characteristics, and 4) cross-sex-typed or sex-reversed persons – individuals whose psychological gender is the opposite of their physical sex, that is, feminine men and masculine women.¹¹ The task for the surveyed persons was to define, by using a 5-point scale, to what extent each of the 35 traits characterizes them. The sense of quality of life was researched using the Sense of the Quality Questionnaire Form – a version modified by M. Oleś (Oleś et al., 2002).

Results

The questionnaire forms were filled in by 70 women between the ages of 41 and 72 (20 women of undefined age). All of them had undergone mastectomies in the past. In the early stages of analysis the group was categorized according to the criteria of time that had passed since their mastectomies. The time range was wide, starting from one year to 22 years. The largest number of women, as many as 40 %, were between 3.5 and 10 years after the mastectomy. Another 30 % were one to three years following the operation. Those between 11 and 22 years after the mastectomy constituted 24 %. Four persons did not specify how many years had passed since the operation. The second stage of quantitative analysis consisted in diagnosing psychological gender types within the surveyed group. These analyses

¹¹ Kuczyńska A. , 1992, An inventory of Psychological Gender, p.26.

showed that the most numerous group defined according to the typology of psychological gender identity is the group of feminine women constituting as many as 58 %, while androgynous women made up 25 % , and undifferentiated persons represented 17 %. What is interesting is that no group of women categorized as masculine appeared among the surveyed persons – a very intriguing result and stimulus for further research on changes in patients’ identity processes.

The first research question was as follows: “Do women of different psychological genders who had mastectomies differ among themselves with respect to sense of quality of life?” In order to investigate this question, single-factor analysis of variance (ANOVA) was used. Psychological gender (three levels) was the independent (grouping) variable, whereas dependent variables were the total result plus four subscales of the Quality of Life Test. Within the confines of analysis for each of the five dependent variables, the following research tools were created:

1. Table with descriptive statistics
2. result of the ANOVA analysis of variance – showing the occurrence of the statistically significant correlation between psychological gender and the dependent variable
3. Table with the *post-hoc* test – analyzing differences between particular levels of psychological gender separately (attention! the Tables show only levels of significance)
4. graph of averages
5. A. Quality of life Satisfaction

Women filling in the subscale “Satisfaction” achieved on average 21.7 points.

Table 1. Descriptive statistics

	Psychological gender	N	Average	Standard Deviation.	Min	Max
Quality of life – Satisfaction	Undifferentiated	9	19.0	2.7	16	23
	Feminine	35	21.3	3.1	10	27
	Androgynous	26	23.1	3.6	14	28
	Total	70	21.7	3.5	10	28

Source: my own elaboration

Single-factor analysis of variance ANOVA reveals that psychological gender significantly differentiates the level of result on the “ Satisfaction” scale – $F(2,67)=5,84$; $p=0,005$. This means that women with different psychological genders have a different quality of life sense on the “ Satisfaction” scale.

Table 2. Single-factor ANOVA.

Quality of life – Satisfaction	Sum of squares	df	Average square	F	p
Between groups	122.2	2	61.1	5.84	0.005
Within the group	700.5	67	10.5		
Total	822.7	69			

Source: my own elaboration

Post-hoc analysis shows that there are statistically significant differences between the androgynous and the undifferentiated group. The first achieved a significantly higher degree of satisfaction. There are no differences between feminine women and the undifferentiated and androgynous groups.

Table 3. Post-hoc test (Tukey’s test).

		undifferentiated	feminine	androgynous
Quality of life – Satisfaction	undifferentiated		0.136	0.004
	feminine	0.136		0.094
	androgynous	0.004	0.094	

Source: my own elaboration

B. Quality of life – Competence

Women filling in the “Competence” subscale scored on average 19.4 points.

Table 4. Descriptive statistics

	Psychological gender	N	Average	Standard Deviation	Min	Max
Quality of Life – Competence	Undifferentiated	9	15.0	8.0	0	26
	Feminine	35	18.7	6.4	0	26
	Androgynous	26	21.9	4.4	6	27
	Total	70	19.4	6.3	0	27

Source: my own elaboration

Psychological gender influences the level of result on the “Competence” scale – $F(2.67)=4.95$; $p=0.01$.

Table 5. Single-factor ANOVA

Quality of Life – Competence	Sum of squares	df	Average square	F	p
Between groups	354.0	2	177.0	4.95	0.01
Within groups	2396.5	67	35.8		
Total	2750.6	69			

Source: my own elaboration

Post-hoc analysis shows that there are statistically significant differences between the androgynous and the undifferentiated group. The first achieved significantly higher scores on the “Competence” scale. There are no differences between feminine women and the undifferentiated and androgynous groups.

Table 6. Post-hoc test (Tukey’s test).

		undifferentiated	feminine	androgynous
Quality of Life – Competence	undifferentiated		0.238	0.011
	feminine	0.238		0.094
	androgynous	0.011	0.101	

Source: my own elaboration

C. Quality of Life – Opportunities

The influence of psychological gender upon the “opportunities” subscale results has not been proved – $F(2.67)=2.09$; $p=0.132$.

Post-hoc analysis has not shown any statistically significant differences among the groups within the “opportunities” scale.

D. Quality of Life – Belonging

Psychological gender also has no statistically significant influence upon the score of the “belonging” subscale – $F(2.67)=2.6$; $p=0.082$. However, this score is close to achieving statistical significance (perhaps in another study it would be possible to define precisely whether this influence exists or not). Post-hoc analysis shows no statistically significant differences among the groups within the “belonging” scale.

E. Quality of Life – the Total Score.

Throughout the entire test, measuring the quality of life women scored on average 89.9 points.

Table 7. Descriptive statistics.

	Psychological gender	N	Average	Standard Deviation	Min	Max
Quality of Life – Total Score	Undifferentiated	9	77.7	19.3	34	98
	Feminine	35	88.6	11.4	47	104
	Androgynous	26	95.8	10.6	59	108
	Total	70	89.9	13.5	34	108

Source: my own elaboration

Analyzing the total score of the quality of life test, it becomes obvious that psychological gender differentiates the level of the total score in a statistically significant way – $F(2.67)=7.68$; $p=0.001$.

Table 8. Single-factor ANOVA.

Quality of Life – the Total Score	Sum of squares	df	Average square	F	p
Between groups	2327.9	2	1163.9	7.68	0.001
Within groups	10156.0	67	151.6		
Total	12483.8	69			

Source: my own elaboration

Post hoc analysis reveals that both androgynous and feminine women achieved higher scores than the undifferentiated women group. There are no statistically significant differences between feminine and androgynous women.

Table 9. Post – hoc test (Tukey’s test).

		undifferentiated	feminine	androgynous
Quality of Life – the Total Score	Undifferentiated		0.05	0.001
	Feminine	0.05		0.065
	Androgynous	0.001	0.065	

Source: my own elaboration

The second research question was the following: “Does the quality of life of women who had undergone mastectomies depend on their age or on the period of time that has passed since the operation?”

In order to verify this question, the Spearman Rank Correlation Coefficient analysis was conducted. The results can be found in the following Table.

Table 10. Results of the Spearman Rank Correlation Coefficient.

		Time after mastectomy	Age
Quality of life – Satisfaction	Correlation coefficient	0.135	-0.101
	P	0.348	0.484
	N	50	50
Quality of life – Competence	Correlation coefficient	0.088	0.018
	P	0.541	0.901
	N	50	50
Quality of life – Opportunities	Correlation coefficient	0.011	0.076
	P	0.939	0.601
	N	50	50
Quality of life – Belonging	Correlation coefficient	0.337	0.052
	P	0.017	0.722
	N	50	50
Quality of life – Total Score	Correlation coefficient	0.183	0.020
	P	0.204	0.891
	N	50	50

Source: my own elaboration

Conclusions: There are almost no statistically significant correlations between the quality of life and age or time after mastectomy. This generally means that the quality of life of women who experienced mastectomy neither depends on the age of women nor on the time that has passed since the operation. The only exception is the significant positive correlation between the time after mastectomy and the “belonging” variable. Women with longer periods of time after their mastectomy have achieved higher scores in this subscale. This result is an inspiration for further analysis, for example, in the narrative mode in order to reveal a point of reference in the context of belonging of women after mastectomy.

Conclusion

Analyzing psychological considerations of women’s success in the fight against cancer, one may notice that a human being’s attitude towards his own disease

is determined by the interplay of cognitive and emotional processes (Steuden, 2002, p. 30). The attitude dynamic and its picture may change depending on the stage of the disease and recovery process. At present, reflections on health and disease more often centre around a holistic, multidimensional model of a human being (cf. Straś–Romanowska, 2005; Dolińska-Zygmunt, 2001), and in this approach health is a process counterbalancing human's needs with resources and requirements imposed on him by the environment. A sign of health is one's ability to achieve integration and a state of relative balance in relation to the natural, physical and social environment, and also the ability to adjust, internally and externally, the psychophysical, subjective, psychosocial and existential dimensions (Straś–Romanowska, 2004). Coping with illness to a great extent reflects thinking which is directed toward evaluating this disease in terms of the context of situation and one's capabilities. One's abilities to function while ill and the satisfaction achieved in regaining a state of health create a sense of belonging to a group of people who experience illness and overcome it. Examples of solution-focused strategies in dealing with disease are actions aimed at reducing the intensity of clinical symptoms, searching for information about the illness, and using them to cope with it. Broadened knowledge of a disease and ways of dealing with it provide opportunities for contentment and optimism, especially in a situation where family and friends' offer acceptance and support. What is important is a person's personal attitude, expressed in the motto "Life is worth the struggle," one of the items in the quality of life questionnaire. Such a personal declaration reflects and creates a sense of personal success. The second way of coping with illness, emotion-focused, encompasses the following ways of acting: denial of the disease, avoiding information about it, diverting one's attention from negative emotions and escaping into alternative forms of activity (cf. Steuden 2002, p. 33). Clinical practice proves that both types of behavior overlap and complement one another (cf. Lazarus, Folkman, 1984). It appears that both the problem-focused and the emotional approach as complements to one another may be observed especially in androgynous women who display such functions in every one of the above-mentioned quality of life dimensions. Androgynous persons are open and willing to acquire a knowledge of the disease which further motivates them to act and helps to reduce the level of negative emotions and creates a sense of controlling the illness. Actually such behavior refers to all the women who took part in the research study, since what distinguishes them from other patients is that they participated in the Polish Amazons Social Movement. It should be emphasized that the most numerous group among the women surveyed were feminine women, and what is surprising – there was a lack of masculine women. At this stage of analyses one may figure out that the experience of disease and mastectomy has

a significant impact on feminine gender identification, stressing its feminine psychological identity. In the next study one might investigate forming gender identity among a more numerous group of women following mastectomy, for example women who do not get involved in Polish Amazons meetings. Obviously such a study would require a researcher with considerable ethical subtlety.

In the article an attempt was made to describe the quality of life of women who fight against illness. Breast cancer is a disease which may raise many questions about the identity of women's gender. It was shown that the longer that time elapses following the mastectomy, the stronger becomes the women's conviction about the meaning of life (expressed in the opinion measurement "Life is okay, but could be better" and "Life is worth the struggle.") The cases of women after mastectomy, discussed in the article, prove that they feel successful to the same extent when compared to others. Their own activity, action and openness towards disease surely results from their not having carried the burden of illness in a destructive way. The process of adjustment to disease may take two forms. The woman in the first instance identifies with the disease and adopts the identity status of a sick person, while the woman in the second instance is aware of the disease's existence and that it requires treatment, yet does not attach negative labels to herself; this attitude stimulates activity in dealing with disease regardless of its type, stage of progression, the changeability of its symptoms, and its expected after-effects (Steuden, 2002, p. 31).

It seems to be necessary for an individual to appreciate the quality of life variables in current positive definitions of health despite the high incidence of chronic diseases – including breast cancer – and to have instilled in him/her from their earliest years a sense of happiness (certain permanent positive attitudes) (Czapiński, 2002, 1988).

The quality of life in oncology (cf. Szewczyk L. et al., 2006, p. 26) and gender identity may be applied in order to:

- individualize the approach to a patient, taking into account his or her condition and overall view of that patient's situation
- make decisions about alternative treatments
- assess the effects of applied treatment
- improve cooperation between patient and doctor
- increase the patient's approval and satisfaction with treatment

Bibliography

Baum M., Saunders Ch., Meredith S., 1995, *Rak piersi/ Breast Cancer* Warszawa: PWN, Springer, p.10.

- Czapiński J., 2002, Szczęśliwy człowiek w szczęśliwym społeczeństwie? Zrównoważony rozwój, jakość życia i złudzenie postępu. *Psychologia jakości życia*, t. I, nr 1; Warszawa: Wydawnictwo SWPS Academica, 9-34.
- Czapiński J., 1988, *Psychologia szczęścia*; Poznań: Wydawnictwo Ademos
- De Walden-Gałuszko K. (ed.), 1997, Ocena jakości życia uwarunkowana stanem zdrowia./The evaluation of the quality of life determined by the state of health. (W:) J. meyza (ed.) *jakość życia w chorobie nowotworowej./ The quality of life in tumour disease* Warszawa: Centrum Onkologii Instytutu im. Marii Skłodowskiej-Curie, 77-82.
- Dolińska-Zygmunt G., 2001, teoretyczne podstawy refleksji o zdrowiu./ Theoretical basis of reflection on health. (W:) G. Dolińska-Zygmunt (ed.) *Podstawy psychologii zdrowia./Foundations of Health Psychology*. Wrocław: Wydawnictwo Uniwersytetu Wrocławskiego, 11-18.
- Dziurawicz-Kozłowska, A. , 2002, Wokół pojęcia jakości życia. *Psychologia Jakości Życia*, Around the Concept of Quality of Life. The psychology of Quality of Life. tom 1, nr 2, 77-99.
- Eagly A. H., Carli L.L., 2009, *Kobiety górą./ Women have the upper hand/*. Gliwice: Helion.
- Grinde B., 2002, Happiness in the perspective of evolutionary psychology. *Journal of Happiness Studies*, 3, 331-354.
- Jaśkiewicz M., 2005, Powstanie z kryzysu, /Rising from crisis. (w:) *Charaktery*, 3, 10-13.
- Kuczyńska A., 1992, Inwentarz do oceny płci psychologicznej./ The Inventory of the Psychological Gender. Warszawa: Polskie Towarzystwo Psychologiczne.
- Lazarus R.S., Folkman S, 1984, *Stress, appraisal and coping*. New Yourk: Springer.
- Lisowska E., 2009, *Kobiecego stylu zarządzania, / Female management style*. Gliwice: Helion.
- Miluska J., 2002, *Płeć kultury./ The gender of culture/*. *Charaktery*, sierpień , 62-64.
- Oleś M., 2010, *Jakość życia młodzieży. W zdrowiu i w chorobie*. Lublin: Wydawnictwo KUL.
- Oleś M., Steuden S., Klonowski P., Chmielnicka-Kuter E., Gajda T., Puchalska-Wasył M., Sobol-Kwapińska M., 2002, *Metody badania jakości życia i psychospołecznego funkcjonowania chorych z zaburzeniami widzenia*. (w:) Oleś P., Steuden S., Toczolowski J. (red.), *Jak światą mniej widzę. Zaburzenia widzenia jakości życia*. Lublin: Towarzystwo Naukowe Katolickiego Uniwersytetu Lubelskiego., 51-68

- Rostowski J., 2005, Rodzinne uwarunkowania kształtowania się tożsamości osobowej człowieka. Family considerations of creation of personal identity. *Psychologia Rozwojowa*, 10, 2, 13-21.
- Siemaszko A., 1993, Granice tolerancji. O teoriach zachowań dewiacyjnych. / The limits of tolerance. On the theories of deviation behaviors. Warszawa: Wydawnictwo Naukowe PWN.
- Studen S., 2002, Z psychologicznej problematyki zdrowia i choroby./ From the psychological issues of health and disease. (w:) Oleś P., Studen S., Toczowski J. (red.), 2002, Jak świata mniej widzę. zaburzenia widzenia jakości życia. / How less of world do I See. The quality of life perception disorders. Lublin: Towarzystwo Naukowe Katolickiego Uniwersytetu Lubelskiego. 27-36.
- Straś-Romanowska, M., 2005., Jakość życia w świetle założeń psychologii zorientowanej na osobę / The quality of life in the light of individual oriented psychology. [w:] *Kolokwia Psychologiczne* pt. Jakość życia w badaniach empirycznych i refleksji teoretycznej / Psychological tests. The quality of life in empirical research and theoretical reflection, / Straś-Romanowska, Maria (red.), Lachowicz-Tabaczek, Kinga (red.), Szmajke, Andrzej (red.). Warszawa: Wydawnictwo Instytutu Psychologii PAN, 2005, Seria *Kolokwia Psychologiczne* / Komitet Nauk Psychologicznych PAN; t. 13.
- Straś-Romanowska, M., 2004, Jakość życia w perspektywie psychologicznej./ The quality of life in the psychological perspective. [w:] Patkiewicz, J. (red.), *Jakość życia dzieci i młodzieży niepełnosprawnej w Polsce i w krajach Unii Europejskiej./The quality of life of disabled children and youths in Poland and in the countries of the European Union.* Wrocław: Studio Wydawniczo-Typograficzne „Typoscript”.
- Straś-Romanowska, M., 1992, Los człowieka jako problem psychologiczny. Podstawy teoretyczne. /Human's fate as a psychological problem. Theoretical grounds. Wrocław: Wydawnictwo Uniwersytetu Wrocławskiego, 42-54.
- Szewczyk L. Wiśniowiecka M., Noczyńska A., Bieniasz J., Wysocka-Łukasik B., 2006, Poczucie jakości życia dzieci chorych na cukrzycę typu I leczonych różnymi metodami insulinoterapii. *Endokrynologia Pediatria*. Tom. 5/2006 Nr 2(15), 23- 28.