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# The Meanders of Femininity. Some Psychological Functioning Aspects of Women following Mastectomy

The metaphor of a river the normal current of which has been disturbed by an unevenness along its bed seems to be a fruitful approximation of psychological processes occurring in the minds of mastectomy patients. The current flow shifts from one riverside to the other in various ways, cutting into new ground layers. From the geological point of view even the meandering river destroys land to a certain extent, altering the riverbed as time goes by.

If we imagine one's identity as solid ground and a crisis experience such as cancer as a river meandering in its valley, we would try to focus on places where this river devastates the most solid parts of a human being. We could think of critical life events such as existence-threatening illness as if they were river meanders, which remain as more or less destructive paths in one's continuity of the *self*.

The tumor occurring in woman's breast is able to enmesh her life span. Breast extraction causes numerous changes in her body image and her sense of femininity. It entails the necessity of psychological adjustment to a new way of functioning, especially considering the gender role. From the first suspicion of cancer changes in their breasts till the end of the oncological treatment they experience constant changes that are able to drive a woman to redefine her femininity. Body changes and the potential loss of attractiveness or the possibility of functioning in her former roles (e.g. at work) makes a woman experience grief and the loss of an important part of *self*. Such a crisis in a post-op woman could result in identity disturbances. On the other hand, when the cancer occurs, it breaks down the ways of one's psychophysical integration. Such situations may even at times spur positive changes. Some resources or developmental possibilities may lay buried deep in the riverbank, waiting to be discovered. The aim of therapeutic work should thus be the reintegration of the new aspects of the *self* with a person's earlier psychological structures. In this way the rehabilitation becomes a creative quest, not only a restoration of an

earlier functioning level. It may be a process of passing through one's life affected in terms of 'I must' or 'I can' to one defined by the phrase 'I am' and of fulfilling one's own individual sense in every single life experience (Frankl 1967). This is what this article refers to.

The most commonly mentioned consequences of a cancer-related illness and treatment are fear, grief, depression and anger (e.g. Juczyński 2000; Chojnacka-Szawłowska 1994). In the case of a radical and mutilating surgery like mastectomy, the consequences also refer to the base of a woman's identity – her own body. Maybe it is the sense of femininity which is primarily being attacked by the breast cancer experiences. Gender stereotypes present in modern culture, especially connected with physical attractiveness, make it difficult for some people to reflect deeply on the psychosocial determinants of sex, which are contained in the gender identity phenomenon. The sense of femininity is defined not only by a woman's physical appearance, but also – maybe primarily – by the way of behaving and reacting to situations (Bem 1997). It's a good time to bring order to ideas regarding femininity. Kaschack (1996) notices that one of the aims of feministic psychology was to legitimize the differentiation of biologically determined, genital-based, sexual identity from gender identity. The latter idea is defined as a set of culture-conditioned features attributed to men and women. The existence of a biological woman needs thus to be completed on the psychological and social level of gender identity development, rather than be described in terms of behavior. In other words, the idea of *gender* means masculine and feminine role patterns, absorbed during the bringing up and socialization process (Wysocka-Bobryk et al. 2001) and is a spontaneous readiness to use the category of sex while relating to the external world (Kuczyńska 1992). Brannon (2002) even talks about a woman's behavior as a role, but a role is still different than an actor's character. The term of role refers to behavioral patterns. But, as Bem notices (2000: 152), 'gender-specific personality [...] is a physically-placed biological structure which is the human body', nevertheless she considers the body as 'not only what people look like [...] but also how they function physiologically, how they move and sense or express their sexual drive'. Femininity in terms of gender identity is a dynamic fusion of biological, behavioral, psychological and social levels of functioning.

Since the 1980s gender identity has been expressed in terms of cognitive schemas, containing the basic assumptions of femininity (Bem 2000). According to the cognitive theory, the *self* is constructed of hierarchically arranged schemas. A more centrally placed schema is more significant for an individual and influences her choices to a greater degree. For patients whose personality is *more* determined by the 'being a woman' category, the gender schema has a more central position in their *self* images (Bem 1976). Their psychical features are more coherent with their biological sex and their behavior, but Bem's assumption is that such functioning patterns are not the best strategies when an individual has to adjust to new conditions (e.g. Bem 1975). She states that gender related behavior arises not only from the global cognitive childhood development, but it is also actively created in relation to

environmental impact, defining masculinity and femininity (Bem 1985). The environment also defines what sorts of breasts woman *should* have. Schemas formation process is more significant than its content, because sex-typed personality is made up of both process and product; besides containing 'feminine features' it is simultaneously the way of reality perception (Bem 2000). Kaschack (1996) considers gender identity as a theoretical construct also integrating an individual's experience strongly saturated by the values of social environment. What does this definition say for the manner of changes in the body image comprehension among the mastectomy patients? Well, gender identity, the starting point of which is one's body experiencing process, broadens here by the way of behavior, a kind of playing the role of femininity, defined to a certain extent by sex stereotypes. The latter emphasizes a body cult rather than gender identity development. Women having experienced extractions of parts of their physical bodies could have illusion they have also lost a part of their identity. But will a woman stop *acting* like a woman even if she only has one breast or none at all?

In Bem's opinion, people differ in their willingness to perceive themselves and the others through the prism of masculinity or femininity. Some people, considered to be androgynous ones, do not have such tendencies to divide individuals, their features or behavior on the basis of culturally binding gender definitions, but on the strength of other determinants (Bem 2000, 1985, 1975). Sexuality and attractiveness are strongly associated with behavior, not exclusively with first- or second-class sex features. In their study, Wysocka-Bobryk et al. (2001) stated the relation between breast cancer and gender identity disorder among post-op women. Their study, based on Bem's theory, proved that among women with breast cancer different patterns of gender identity occurred, and half of them demonstrated an undetermined pattern. These women had a tendency towards risk avoidance and action withdrawal, which is a maladaptive way of coping with cancer. The authors conclude that such data do not convince that undetermined pattern of gender identity is a risk factor, or the consequence of the influence of breast cancer experience on personality structures. Women in the quoted study were examined about three weeks following surgery. It is possible that repeating gender identity assessment after some time could clear away the doubts.

Let us consider gender identity to be the core of *self* image – the deepest level of identity. A lot of studies refer to the impact breast extraction has on the psychological functioning of women. I'm thus going to present a short review of studies concerning the influence of body changes on psychological, social and behavioral functioning of women after mastectomy. Such a review of current research related to constructs connected with gender identity determinants of women following mastectomy could shed more light on the matter of how deeply breast cancer experience and treatment meanders their sense of femininity and if it simultaneously becomes a chance for discovering new levels of being a woman. Accents postulated here shift within the confines of the identity of post-op women requiring further specification.

What processes set in motion the trauma of breast extraction and what follows such an experience? Does an identity crisis have to accompany mastectomy?

## The Loss of femininity?...

Mastectomy consist of extracting the breast muscle together with the content of the armpit. The amount of tissue extruded depends on the stage of the cancer. This treatment method is radical and its impact on overall organism functioning is distinct and ranges from posture changes in coronal plate, movement, breathing and circulation disorders to lymphatic swelling. These disturbances are not the only consequences but they are exhaustively discussed in literature (Mika 1991; Bąk 2004, and others).

Most of the post-op women recall touching the operated places with the hope that doctors have spared their breasts. But most of the surgeries are radical ones. Touching one's own mutilated flesh activates the reaction of grief and loss connected to the changes to body image. It is not clearly confirmed that such changes result in lower self-acceptance or worsened psychosexual adjustment to the effects of surgery. Keeping women informed about the aim of the radical prophylactic surgery needed to reduce the risk of the disease spreading or returning facilitates the acceptance of one's own deformity and abovementioned disturbances. The authors list fear, depression (mourning) or low self-acceptance among the psychological reactions to breast extraction. Biological fear for life and health escalated just after the surgery subsides with time into the social fear (Adamczak 1988 in Chojnacka-Szawłowska 1994) which involves sexual functioning with being aware of own disability (Wimberly et al. 2005).

Among long term mastectomy results listed most frequently by the examined women there was the drop in the feeling of own physical attractiveness and sexual disorders in intimate relationship with a partner, which is well documented in literature. One research conducted among afro-American women showed that the drop in the feeling of own physical attractiveness was not influenced by the kind of surgery (either preserving the breast or not) but by further treatment (chemotherapy). Complaints regarding physical attractiveness were greater in the group of mastectomy patients treated with chemotherapy (Taylor et al. 2002). The authors quote results gathered by other researchers, which show ethnic differences in personal body perception among healthy women. In comparison with Caucasian women, afro-Americans consider their selves to be more attractive, they are happier with their bodies and pay less attention to physical appearance and self-esteem, which might be connected to more religious and traditional upbringing.

Miedzińska et al. (2004) noticed differences among women from different ethnic groups inhabiting USA in terms of the quality of life index after experiencing

a breast tumor and its treatment. They say that among afro-Americans the indices of social support, sexual functioning and finding the sense to one's life were higher in comparison to Latina, Asian and Caucasian women. In Polish research, Walęcka-Matyja and Rostowska (2002) state that women following mastectomy are characterized by a higher conformity between real and ideal self-image, which is connected with a higher self-appraisal level in comparison with healthy women, and implement the stress avoidance coping style. The ideal *self*, according to Łukaszewski (1974 in Chojnacka-Szawłowska 1994), is developed by self transfer from the past to the future, in the case of people suffering from cancer, from the pre-cancer period, so as behavior regulation standard it may influence the lowering of self-esteem during the illness. Chojnacka-Szawłowska (1994) was examining the level of self acceptance understood as a gap between the real and the ideal *self* in women during cancer treatment. The self-acceptance level in patients following mastectomy was the same as in the group of healthy women. According to the author, adequate knowledge about one's own illness coexists with more realistic self-esteem and optimal self-acceptance level.

In spite of the changes to the image of one's own body after breast removal surgery, there are reports about faster return to a form of equilibrium and lower fear after nipple recovery operation, preferably simultaneous with it's amputation (Kruszewski et al. 1999). Otherwise, the other research shows no difference between the group of women following mastectomy alone in comparison with women who underwent simultaneous breast reconstruction, in terms of levels of depression, fear, changes to the body image, in the period of 3 to 15 months following surgery (Holly et al. 2003). Results of various research into post-mastectomy grief and results of its immediate or delayed reconstruction are ambiguous.

One's own body perception must thus be the most important circumstance in the process of psychosexual adaptation following mastectomy, resulting in the loss of a part of the self. Maybe the value system of an individual plays a greater role in the building of the picture of self than one might suppose. Research results are not coherent in this matter. In their research, Hopwood et al. (2000) noticed that the majority of post-op women did not report any major complaints about change of image of own body and mental disorders connected with it. Their problems were connected with the feeling of lower physical and sexual attractiveness, increased focus on these problems and of a lowered sense of femininity. That would be the psychosocial consequence concerning other people's acceptance of post-op women.

The other research examined how the quality of a partnership in a relationship influences women's functioning after breast removal. Wimberly et al. (2005) showed that the main predictor of good sexual and emotional adjustment was observed in women whose partners were engaged in the relationship and expressed support while building emotional bounding. Authors were interpreted in the results showing that the feeling of a partner being interested in the intimate relationship caused women to feel more feminine and more satisfied with the relationship, which might lead to more self-confident behavior towards the partner, causing the partner to be even

more interested in the woman. It turned out that intercourse itself was generally less important than the partner's interest.

In the study by Hopwood et al. (2000), the changes referred to were to sense of femininity rather than body image. Similarly in the next quoted study – Wimberly et al. (2005) psychosexual adjustment, applying to, among others, the new body image acceptance, was connected to quality of partner bounding. It is quite possible that regulatory function modulating cognitive and emotional processes and individual's behavior is to a large extent related to the overall identity or culturally shaped gender definition, in spite of the body focus observed in mastectomy patients. Personality compensative mechanisms following surgery can participate in the new accents ranging from biological sex to its psychological extension – gender identity. Such mechanisms could either cause redefining one's identity from 'I am a woman' to 'I Am'. The occurring changes would fit more with self-recognition or development of *one's own* sense of femininity . They could also lead to the displacement of gender identity schema to a different level of the *self* structure.

## ...or new dimensions of femininity?

Crisis expressed as breakdown of extant psychophysical integration may be connected with mutilating surgery like mastectomy and with the experience of cancer. Its potential impact on the psyche could vary from the breakdown of adaptive mechanisms to the growth one's own abilities or the sense of life. One of the first psychotherapists to talk of the sense of suffering was Viktor Frankl. His reflection was operationalized in a more precise matter and formulated as the term *Posttraumatic Growth* (PTG), initiated by Tedeschi and Calhoun (1996). They defined this construct as 'the experience of positive change that occurs as a result of struggle against a highly challenging life crisis', manifested as 'increased appreciation of life in general, more meaningful interpersonal relationships, an increased sense of personal strength, changed priorities' (Tedeschi, Calhoun 1996:1). In their opinion, it is not trauma that activates the growth process, but cognitive and emotional processes connected with trauma. Such processes can cause a crisis to appear or not. Development can be stimulated by personal resources like extraversion, openness to experience or optimism. In a Polish study, Widera et al. (2003) stated that a high level of optimism and satisfaction with life prior to illness translates into a lower number of *posttraumatic stress disorder* symptoms following mastectomy.

So it appears that in moments of trauma a person sets in motion emotional and cognitive processes in order to cope with the harmful event: she constructs narrations allowing her to order different aspects of the experience and feelings connected with it, even in the context of her basic concepts and aims. An individual feels usually that her life is divided into two parts: the 'before' and the 'after' – illness

becomes the turning point (Calhoun, Tedeschi 1996). She could be convinced that it is impossible to realize her aims and intentions and that her earlier outlook does not square with the present reality. She starts feeling grief and reflecting on ways to avoid the trauma. The aforementioned processes lead to the lowering of mood and increase in stress level. It takes time talking out the trauma with a supportive group people in order for the patient to come to understand it. Weiss (2004 a, b) noticed that a secure marital relationship helps women following mastectomy to focus on cognitively working out their situation and broadening their behavior repertoire. The second factor assisting coping with developmental breast cancer trauma is contact with persons who experienced similar situation and found sense and even benefits in this crisis. Weiss stated also that posttraumatic growth in operated women occurred soon after surgery, however in their husbands PTG appeared later. All these processes mean changes to earlier created cognitive schemas, which have influenced the various factors leading to growth. According to the functional-descriptive model of Tedeschi and Calhoun, a greater number of invasive trauma-related thoughts allows for more positive coping. In the authors' opinion, developmental changes refer to habits, discovering new possibilities, interpersonal relationships, personal strength (identity), spirituality and life affirmation.

The *Posttraumatic growth* construct was also defined in terms of finding benefits, understood as a process or the result of coping with trauma. Helgeson et al. (2006) conducted metaanalysis of many works connected to PTG construct. They focused mainly on mediators functioning between the finding of benefits in trauma and psychological health. In their opinion, study results suggest that there are some conditions under which individuals are most likely to extract benefits from negative consequences of hard life events. The finding of benefits and later posttraumatic growth is connected with mental health, when intrusive thoughts and reminiscences about illness are more intensive. Lack of data coherence occurs when researchers treat such thoughts as stress markers. As mentioned above, many authors presume that these are cognitive processes allowing to comprehend trauma, thus cognitive biases should be considered as stress reducers. It is quite possible that perceived growth refers to the initial intensified stress. It was also observed that the passage of time makes searching for benefit more effective. Depression levels decrease and greater positive well-being occurs. In the case of fear, searching for benefits shortly after trauma leads to its decrease. It is thus a practical hint to note the time elapsed since surgery.

Authors of the Constructivist Self Development Theory and the Effects of Trauma, Saakvitne et al. (1998), relate to the content of PTG to a larger extent than Tedeschi and Calhoun. They indicate five areas which are affected by trauma. These are: one's ways of understanding the self and the world (also spiritual beliefs); self-capacities of recognizing, tolerating and integrating of affect and also maintaining interpersonal relations; *ego*-resources like self-observing, goal-achieving in a mature way and social skills; central psychological needs expressed in terms of cognitive schemas of safety, trust, control, esteem and intimacy; perceptual and memory sys-

tems (biological level). The mentioned areas reflect ways of organizing experience following trauma: the event itself, its context, consequences and its impact on one's beliefs regarding the self and others. We should take into consideration all the mentioned areas during trauma coping. When trauma exceeds one's tolerance threshold, it may result in need for dissociation and defense through amnesia, which excludes conscious cognitive processes. Individual experience also meets social reception, shaping one's own process of sense construction – inner resources are connected to the social background. From the developmental point of view, the most significant changes occur in identity, outlook, spirituality and fundamental beliefs. Trauma invites a person to battle with his basic frame of reference and it is the area most subject to growth. Unfortunately, changes may result in self-withdrawal and identity continuity interruption, but according to the quoted model, growth and pain are inseparable from trauma and loss. The aim of therapeutic work would thus be integrating the past and the present and finding strengths in weaknesses. Authors place emphasis on the fact that adaptation processes refer to the whole person in her context. They stress that various parts of the *self* may be transformed by the trauma experience. It seems to be a tempting matter that the coping process initiates global changes in many areas of a person's functioning, with time progressing into growth.

## Towards reintegration - from being handicapped to just Being

The searching for sense together with changing are dynamic processes requiring one's own involvement. Growing up in a society where we come into contact with numerous stereotypes, it is not easy to break with the omnipresent tendency to oversimplify our inner image of reality – our own stereotype. It seems to be even more difficult following mastectomy, when the body is preoccupied with pain and fright, making the thought of disability the foremost. Immediately following the surgery, fear becomes the center of one's experience, focusing all thoughts and feelings. It may seem to be obvious that there is a hole in a woman's identity she is unable to fill. Continuous retelling of one's own story to other patients, family and friends makes it easier to carry on the dialogue with one's own inner voice and to meet the new perspectives presented by the social environment. During the formulating of the story, a woman's gender identity is being retold. It is possible that her overall identity is being told over and over again. Such process would seem to cause stress to increase. Trauma is not inevitably connected with the identity crisis, because temporal disintegration may lead to growth, but it needs time and words to give the experience a name.

We may supposedly never enter the same river twice, and even in this situation the whole landscape is transformed. How to find a point of support with the only constant being changed, the passage of time, a story told for the moment and the

clash of land and river. When river penetrates new ground layers in a meander, it destroys it and simultaneously creates a new landscape. Creative rehabilitation could be based on just such experiences of destruction and formation. It needs gradual rising to the sky to see from the bird's eye view what has arisen. This is the end of the journey. What may make the tiring flow of experiences less exhaustive is the 'basic trust in Being' (Frankl 1967:57). There must be a sense of one's existence somewhere.

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## Meandry kobiecości. Wybrane aspekty funkcjonowania psychologicznego kobiet po mastektomii


### Streszczenie

Pomimo zmian w obrazie ciała u kobiet po mastektomii, ich kobiece poczucie tożsamości w podstawowym wymiarze może nie być aż tak zagrożone, jak to intuicyjnie zakładamy. Tożsamość płciowa jest zjawiskiem złożonym. Możliwe jest, że strata fizyczna powoduje przeniesienie uwagi pacjentki z biologicznego wymiaru kobiecości na jej aspekty behawioralne, psychologiczne i społeczne. Rehabilitacja powinna być procesem reintegrującym przeszłość i teraźniejszość *jaźni*, by stymulować pooperacyjną rekonwalescencję kobiet – od koncentracji na atrybutach płciowych do całkowitego utożsamienia się ze swoją płcią.