Relationship between Psychological Adjustment and Occupation in Laryngectomized Patients in Japan

Kumiko Kotake1, Kazuyo Iwanaga2, Yoshimi Suzukamo3, Ichiro Kai4, Kaori Haba1, Aya Takahashi2, Juntendo University Faculty of Health care and Nursing 1, School of Nursing Faculty of Medicine, Fukuoka University 2, Department of Physical Medicine and Rehabilitation, Tohoku University Graduate School of Medicine 4, The University of Tokyo 3, Saitama Prefectural University, Faculty of Health Sciences Department of Nursing 2

Objectives

The purpose of this study was to clarify the relationship between the psychological adjustment laryngectomized patients and changes in their working situation.

Methods

Recruit: A total of 27 participated in the study.
Setting: From a population of candidates scheduled to undergo laryngectomy for perilyngeal cancer at the head and neck wards of a cancer Hospital and three local regional hospitals.
Surveys (four times): Before surgery (face-to-face), three months, six months, and a year after discharge (by mail).
Dependent variable: Psychological adjustment (NAS-J-L)
Independent variables: Occupation before surgery, Currently working, and the reason for retirement if they were retired.
Basic characteristics: Age, gender, family structure (living alone, or with two or more people), diagnosis, surgical procedure, and psychological problems at discharge such as difficulty swallowing and constipation.
Analysis: A repeated measures GLM method

Instruments:

The Japanese version of the Nottingham Adjustment Scale, Laryngectomy (NAS-J-L), modified by Yaguchi et al. (2004): seven subscales and 27 items that using a 4-5 point Likert scale of the each item.

- anxiety/depression: six items (e.g., “I have no energy and feel depressed”)
- self-esteem: three (e.g., “I feel totally useless from time to time”)
- self-knowledge: three (e.g., “I do not need to be anxious about losing my voice”)
- positive affirmation: six (e.g., “I feel that my life is very significant even after losing my voice”)
- attitude: four items (e.g., “Many people with vocal impairments generally consider losing their voices as the worst incident to have happened”)
- self-efficacy: three (e.g., “I tend to give up easily”)
- locus of control: two (e.g., “I will make only very little progress in rehabilitation”)

Attributional style, which was part of the original scale, was found to work differently from other subscales (Dodds et al., 1993).

Consequently, it was proposed to be excluded by Suzukamo et al. (2006) and was thus excluded from the NAS-J-L.

Discussion

The higher the points in each subscale, the higher the psychological adjustment. This scale has established reliability (Cronbach’s alpha coefficients: 0.69-0.91), validity of the structural concept, and criterion-related validity.

The difference in occupational status over time was not significant. Some of retirees have depression or cancer recurrence. In addition, anxiety/depression, attitude and positive affirmation were low in working younger patients (less than 64 years). In attitude and positive affirmation, working older (more 65 years) decrease to a year after discharge.

Locus of control was lower in working patients living in two-person households. Patients living alone decrease in Locus of control.

For working patients living in two-person households, there is the possibility of a sense of loss in being able to hold a social role. Also, results suggested that compared with retiring older patients, working older patients experience more problems.