InterAcción y PerspectivA

Revista de Trabajo Social

ISSN 2244-808X
D.L. pp 201002Z43506

Julio-Diciembre 2023
Vol. 13 No. 2

Universidad del Zulia
Facultad de Ciencias Jurídicas y Políticas
Centro de Investigaciones en Trabajo Social

Interacción y Perspectiva
Revista de Trabajo Social
Vol. 13 Nº2 256-268 pp.
Julio-diciembre

Dep. Legal pp 201002Z43506
ISSN 2244-808X

ARTÍCULO DE INVESTIGACIÓN

El papel de la competencia de afrontamiento del individuo en la aplicación del proceso de rehabilitación

DOI: 10.5281/zenodo.7812215

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Resumen

El objetivo fue examinar las características de compromiso con la rehabilitación y las estrategias de afrontamiento de los pacientes. El estudio se realizó en la Oficina Federal de Evaluación Médica y Social del Ministerio de Trabajo y Bienestar Social de la Federación Rusa entre 2015 y 2018 y se basó en una muestra de pacientes (n = 510 personas) con la condición de discapacidad básica. El examen se realizó en diferentes situaciones de la vida: inspección médica y curso de rehabilitación médico-social de pacientes hospitalizados. Eran uniformes en cuanto a sus principales características clínico-demográficas y sociales de los pacientes (sexo, edad, estado civil y educativo, entidad nosológica, gravedad y duración de una enfermedad, salvo la discrepancia estadísticamente fiable en la situación laboral). En el curso del estudio se utilizaron las escalas del mecanismo de afrontamiento de Heim (L. Wassermann) y la Evaluación del Compromiso de Rehabilitación (ARC) (E.V. Morozova). Los resultados obtenidos caracterizan la especificidad del compromiso de rehabilitación y la competencia de afrontamiento, siendo ambos la proactividad psicológica de los pacientes en los diferentes grupos estudiados. El estudio de indicadores psicológicos en grupos de personas con diferente actitud hacia el estado de discapacidad reveló mecanismos psicológicos para distintos patrones de compromiso de rehabilitación. Por parte del grupo de personas que no se identificaron como discapacitadas, el estudio reveló una competencia de afrontamiento bien formada que implicaba principalmente el uso por parte de los pacientes de estrategias de afrontamiento adaptativas sin ninguna respuesta emocional negativa.

Palabras clave: Proactividad personal, Competencia de afrontamiento, Mecanismos de afrontamiento, Compromiso de rehabilitación, Diagnóstico psicológico, Rehabilitación psicológica.

Recibido: 1/03/2023 Aceptado:31/03/2023

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Abstract

The role of coping competence of the individual in the implementation of the rehabilitation process

The aim was to examine psychological characteristics of a person suffering from disabling conditions (including characteristics of commitment to rehabilitation and patients' coping strategies). One of the crucial resources ensuring a person's psychological proactivity is a so-called coping competence, i.e. a person's conscious ability by adaptive ways to deal with tough life situations. The study was conducted in the Federal Bureau of the Medical and Social Assessment of the Ministry of Labour and Social Welfare of the Russian Federation in 2015-2018 and was based on a sample of patients (n = 510 persons) with the basic disabling condition. The examination was conducted in different life situations: medical inspection and in-patient medico-social rehabilitation course. They were uniform in terms of their main clinic-demographic and social characteristics of patients (gender, age, marital and educational status, nosological entity, the severity and duration of a disease, except for the statistically reliable discrepancy in the employment status). The Heim's coping mechanism scales (L. Wassermann) and Assessment of the Rehabilitation Commitment (ARC) (E.V. Morozova) were used in the course of the study. The results obtained characterize the specificity of rehabilitation commitment and coping competence, both being patients' psychological proactivity in different groups studied. The study of psychological indicators in groups of persons of different attitude towards disability status revealed psychological mechanisms for different patterns of rehabilitation commitment. On the part of the group of persons not identifying themselves as being disabled the study revealed a well-formed coping-competence involving primarily patients' use of adaptive coping-strategies without any negative emotional responses.

Key words: Personal proactivity, Coping-competence, Coping-mechanisms, Rehabilitation commitment, Psychological diagnostics, Psychological rehabilitation.

Introduction

At present, the international community highlights a higher rate of disability in a population and emphasizes particular importance of related social challenges regarding the improving of the approaches to the rehabilitation process implementation. The World Report on Disability of the World Health Organization notes that over a billion people, i.e. 15 per cent of the world population, in comparison with the previously reported by the WHO level of 10 per cent, live with some form of disability. The international community's great concern is the prevalence of disability due to diseases such as malignant neoplasms; circulatory system diseases; bone and muscular disorders and connective tissue disorders. This triad constitutes the disability structure in the Russian Federation.

At present, as estimated by the Federal Public information system "Disabled Persons Registry", there are 11,8 million persons with disabilities certified in accordance with the procedure established under legislation of the Russian Federation, which constitutes approximately 9,5% of the total population of the country. Of these, circulatory system diseases constitute 35,5%, bone and muscular disorders and connective tissue disorders – 22,6%; malignant neoplasms – 11,8%.

The abovementioned diseases cause serious limitations in the performance of daily activities, including impairment of working capacity, which requires measures of social and psychological protection such as a comprehensive rehabilitation approach.

While not denying the pivotal role of medical rehabilitation aimed at restoration of functional deficiencies of the body and prevention of the onset or aggravation of disability, the international community highlights that the rehabilitation and habilitation of persons with disabilities cannot be limited exclusively or primarily to medical measures.

The persistent nature of health conditions of persons with disabilities makes it necessary to implement consistent measures, including rehabilitation measures aimed directly at rehabilitation of a person, the objective of which is to ensure social rehabilitation and social integration (Spiridonov et al., 2018; Wondergem et al., 2022).

Rehabilitation is always planned on the basis of medical data which practically allows to assess rehabilitation capacity and prognosis, to define objectives and relevant methodological approaches to the implementation of the rehabilitation process.

With regard to psychological rehabilitation of patients, it is essential to take their functional and personal components into account. The functional component of psychological rehabilitation capacity implies interventions (the improvement of the attention function, memory, thinking abilities, mental capacity in general, etc.), allowing for operational resource and actual human functioning. However, not only may higher mental functions allow a person to function normally. Indeed, while retaining mental capacity as well as memory, attention, sensory capacities which function within normal parameters, a person might not be personally proactive and might stay reluctant to the rehabilitation process, which requires psychological intervention for activation of personal resources aimed at effective fulfilment of the wide range of rehabilitation

objectives (Scholten et al., 2018; Ministry of Labor of Russia, 2019; Mol et al., 2021; Fisenbeck et al., 2022; de Graaf et al., 2022).

Clinical and medical expert practice of different medical specialists validates the truism that the severity of the disorder a person suffers does not always correspond to the rehabilitation outcome. Indeed, some persons, though having significant functional deficiencies, are able to accumulate their psychological resources to directly combat a disease, overcoming life limitations attributable to the disease by means of medical and social rehabilitation. However, unfortunately, in certain cases there were no positive rehabilitation outcomes (despite there being minor functional disorders) both in terms of medical and social rehabilitation, because a person was not eager to recover (Raspopova et al., 2018; Van Diemen et al., 2018; Keramat Kar et al., 2019; Scholten et al., 2020; Ying et al., 2022).

Consequently, apart from operational characteristics, the crucial psychological mechanism of the implementation of the rehabilitation process is personal proactivity based on different psychological characteristics of a person. In any case, the opposite attitude of a person leads to the lack (or deterioration) of rehabilitation impact amid psychological and social maladjustment (Morozova et al., 2018; Mikhailov et al., 2020; Welten et al., 2022).

In this regard, measures aimed at detection and prompt personal risk correction should be a priority for psychologists from the onset of the disease and periodically carried out at all its stages.

The International Classification of Functioning Disability and Health (ICF) presents a functioning human model that comprehensively reflects the interrelationships of its main components: including the functional factor (directly reflecting health indicators); the environmental factor (reflecting barrier or supporting environmental factors), as well as the personal trait factor (reflecting the activity characteristics of the individual such as activity and participation) (Shostka et al., 2003; Ministry of Labor of Russia, 2019).

Personal "activity and participation" can be considered related to the functioning of an individual in periods of illness as a resource that provides psychological self-regulation of the subject's activities to solve relevant medical and social problems during this period. One of the most important resources that ensure the psychological activity of the individual is the so-called coping competence, i.e., the conscious ability of an individual to consciously adapt to various difficult life situations (Nabiullina & Tukhtarova, 2003; Scholten et al., 2018).

A disabling disease is definitely a difficult life situation that requires a person to activate personal resources. The system of coping mechanisms is one of the most important psychological resources of an individual implemented by a person through emotional, cognitive and behavioral strategies, which are divided into adaptive, relatively adaptive, and maladaptive strategies (Nartova-Bochaver, 1997; Nabiullina & Tukhtarova, 2003). Mastering the adaptive repertoire of coping strategies and their adequate situational application is the key to socio-psychological adaptation.

Materials and methods

The study was conducted in the Federal State Budgetary Institution "The Federal Bureau of the Medical and Social Assessment" of the Ministry of Labour and Social Welfare of the Russian Federation (FSBI FB MSA of the Ministry of Labour and Social Welfare of the Russian Federation) in 2015-2021 and was based on a sample of patients (n = 510 persons) with the basic disabling condition. The study used certified, valid and well-proven techniques.

The examination was conducted in different life situations: medical inspection and in-patient medico-social rehabilitation course. They are uniform in terms of their main clinico-demographic and social characteristics of patients (gender, age, marital and educational status, nosological entity, the severity and duration of a disease, except for the statistically reliable discrepancy in the employment status). Patients with malignant neoplasms – 102 people (20%), patients with circulatory system diseases – 102 people (20%), patients with bone and muscular disorders and connective tissue disorders - 102 people (20%), patients with endocrine and metabolic disorders (chronic endocrine disease), of whom patients with type 1 diabetes - 102 people (20%) and with type 2 diabetes - 102 people (20%) (Morozova et al., 2018).

The presented results reflect the specifics of rehabilitation adherence and coping competence as the psychological activity of people in various groups studied using the following methods: Coping mechanisms' diagnostics by E. Heim (L. Wasserman) (Nabiullina & Tukhtarova, 2003); Assessment of rehabilitation adherence (ARC) by E.V. Morozova (2020).

Patients were examined in periods of medical expert examination based on the classifications and criteria of disability assessment in force in the Russian Federation (Ministry of Labor of Russia, 2019) and the inpatient program of medical and social rehabilitation in the Federal State Budgetary Institution Federal Bureau of Medical and Social Expertise of the Ministry of Labor of Russia. The first group (n=360) is 70%, which was in the period of medical and social expertise regarding challenging the disability decision. Patients in this group either claimed to be considered disabled for the first time or claimed to return the previously established disability group 2 after determining the fact of partial rehabilitation, justifying a decrease in the severity of the disability from group 2 to group 3, or appealed the decision to lose the status of "disabled" after determining the fact of full rehabilitation.

The criterion for inclusion in this group was a negative decision of the Federal State Budgetary Institution Federal Bureau of Medical and Social Expertise of the Ministry of Labor of Russia regarding determining the status of "disabled" or aggravation of the existing disability group. The psychological activity of the patients in this group was characterized as maladaptive, since they categorically rejected the validity of the expert decision, fixed on the idea of unfair loss or reduction of disability (or unfair decision of doctors not to determine disability), showed pronounced negativism towards the expert commission, often behavioral aggression, and protested the expert decision three times

(at the district, regional and federal levels in the Federal State Budgetary Institution Federal Bureau of Social and Medical Expertise of the Ministry of Labor of Russia). It can be stated that the psychological activity of patients in this group is not aimed at active social recovery activities, but at protest activity, rent behavior, sometimes aggressive rent behavior due to emotional instability, frustration, and psychological alienation of the fact of changing social status when being fixed on the "disabled" status (Morozova, 2020; Mol et al., 2022).

The second group consisted of patients with the same diseases as the patients in medical expert examinations (n=150) is 30%. However, they did not consider themselves to be disabled and were in the mode of an inpatient program of medical and social rehabilitation in the clinic of the Federal State Budgetary Institution Federal Bureau of Social and Medical Expertise of the Ministry of Labor of Russia. We emphasize that the patients in this group did not differ in the main clinical, demographic, and social indicators (gender, age, family and educational status, nosological entity, severity and duration of the disease), and the main criterion to be included in this group was the absence at this stage and earlier of the status of "disabled," as well as their lack of intention to register disability in the near future.

Objective indicators of rehabilitation adherence characterized the psychological activity of individuals in this group: in terms of systematic completion of medical and social rehabilitation programs, active involvement in life activities despite a disabling disease (including actual employment, by the indicator of which this group statistically differs ($p < 0,01$) with the group of expert patients), and interest in participating in various social rehabilitation activities (including attending psychologist sessions, different rehabilitation actions), and an active life stance in general.

Differences in the social behavior of patients in these comparison groups along with the uniformity of the main clinical, demographic and socio-environmental indicators are also confirmed by the results of the "Assessment of Rehabilitation Adherence" method, which characterizes the level of rehabilitation adherence of an individual (Morozova, 2020), which justifies the need to study the psychological mechanisms that determine different rehabilitation adherence and adaptive psychological activity of an individual suffering from a disabling disease.

Results

The results of the comparison of psychological indicators using the "Assessment of Rehabilitation Adherence" method are presented in Table 1 (Morozova, 2020), which studies the individual's adherence to rehabilitation not only in terms of patient behavioral compliance but also their activity concerning the implementation of social recovery in the leading spheres of life (see Table 1).

Table 1

Comparison of groups of patients who classify and do not classify themselves as disabled, by rehabilitation adherence indicators

Psychological parameter	Social situation (claiming disability "YES" / "NO")		Level P
	M ± S (N=360) Yes	M ± S (N=150) Not	
Positive self-belief	2,66 ± 0,75	3,80 ± 0,40	<0,0001
Planning for the future	2,15 ± 0,80	3,41 ± 0,52	<0,0001
Will and responsibility for your health	2,17 ± 0,71	3,60 ± 0,52	<0,0001
Discipline in treatment	3,08 ± 0,46	3,78 ± 0,42	<0,0001
Focus on health-preserving activities	2,01 ± 0,88	3,71 ± 0,47	<0,0001
The total score characterizing the locus of control and focus on health-preserving activity	12,08 ± 2,53	18,30 ± 1,53	<0,0001
Professional / educational self-realization	1,70 ± 0,94	3,58 ± 0,57	<0,0001
Creative self-realization	2,70 ± 0,62	3,84 ± 0,37	<0,0001
Sociocultural activity	2,08 ± 0,70	3,51 ± 0,54	<0,0001
Self-realization in interpersonal relationships	2,71 ± 0,86	3,79 ± 0,42	<0,0001
Implementation of household living arrangements	2,76 ± 0,79	3,97 ± 0,18	<0,0001
The total score, reflecting the activity and participation in the implementation of life	11,91 ± 2,43	18,69 ± 1,27	<0,0001
Overall cumulative indicator (Level of adherence)	24,02 ± 4,30	36,99 ± 2,21	<0,0001

Source: Authors development

Table 2 below shows the results of comparing coping strategies studied using the coping mechanisms' diagnostics by E. Heim (Nabiullina & Tukhtarova, 2003) in groups of patients who claim and do not claim disability (see Table 2).

Table 2

Characteristics of individuals who classify and do not classify themselves as disabled, according to coping strategies

Indicator	Social situation (claiming disability "YES" / "NO")			Level P
	M ± S (N=360) Yes	M ± S (N=150) Not		
Behavioral coping strategies				
Abstraction	1,7 ± 1,3	3,6 ± 1,1		<0,0001
Altruism	2,2 ± 1,5	3,6 ± 1,1		<0,0001
Self-isolation	1,9 ± 1,6	1,0 ± 0,8		<0,0001
Compensation	1,0 ± 1,1	2,2 ± 1,4		<0,0001
Constructive activity	1,1 ± 1,1	3,2 ± 1,2		<0,0001
Avoidance, care	1,9 ± 1,5	0,1 ± 0,3		<0,0001
Appeal	1,7 ± 1,4	3,2 ± 1,2		<0,0001
Cooperation	1,5 ± 1,5	3,1 ± 1,3		<0,0001
Sum of behavioral coping strategies Sum of behavioral coping strategies	13,0 ± 5,1	20,1 ± 3,9		<0,0001
Cognitive coping strategies				
Humility	1,9 ± 1,3	2,9 ± 1,4		<0,0001
Ignoring reality	1,8 ± 1,4	3,0 ± 1,2		<0,0001
Maintaining composure	1,9 ± 1,5	3,0 ± 1,4		<0,0001
Problem analysis	2,0 ± 1,4	2,8 ± 1,5		<0,0001
Comparison	1,6 ± 1,4	2,9 ± 1,5		<0,0001
Religiosity	1,7 ± 1,2	1,7 ± 1,2		0,6901
Making sense	1,9 ± 1,4	2,6 ± 1,5		<0,0001
Setting your own value	1,7 ± 1,4	2,5 ± 1,5		<0,0001
Dissimilation, underestimation of the problem	1,6 ± 1,6	2,7 ± 1,4		<0,0001
Confusion	2,7 ± 1,3	1,1 ± 1,1		<0,0001
The sum of cognitive coping strategies	18,7 ± 5,4	25,1 ± 9,3		<0,0001
Emotional coping strategies				
Protest	2,0 ± 1,5	1,0 ± 1,2		<0,0001
Despair	1,6 ± 1,6	1,0 ± 1,4		0,0035
Expressed aggressiveness	1,8 ± 1,6	0,4 ± 0,9		<0,0001
Suppression of feelings	2,4 ± 1,5	0,8 ± 1,2		<0,0001

Optimism	1,6 ± 1,4	2,6 ± 1,6		<0,0001
Hopelessness	2,0 ± 1,5	0,8 ± 1,2		<0,0001
Self-blame	1,2 ± 1,4	0,5 ± 1,0		<0,0001
Passive collaboration	1,4 ± 1,4	1,8 ± 1,3		0,0027
The sum of emotional coping strategies	13,0 ± 6,3	9,0 ± 5,0		<0,0001

Source: Authors development

The analysis of the research results on coping strategies revealed radically different mechanisms of psychological activity of people in the compared groups.

Discussion

The maladaptive orientation of patients in the group of expert subjects, both concerning their inadequate "Internal Picture of Disability" and avoiding active social interactions in the direction of protest behavior, is objectified by the results obtained through the above methods. The rehabilitation adherence of patients in the studied groups has significant differences in favor of a higher adherence of people who do not consider themselves to be disabled.

All the psychological parameters studied by the "Assessment of Rehabilitation Adherence" methodology reveal statistically significant differences in the indicators in the groups, both on the Health-Saving Activity Scale and Activity and Participation of an Individual in Life Activities Scale and, consequently, on the general indicator of rehabilitation adherence.

It should be emphasized that the group of individuals who do not consider themselves disabled and rehabilitate outside the status of "disabled" with the support of their own resources has a high rehabilitation adherence, which orients an individual to activity and participation in the rejuvenation and self-realization in the leading areas of social relations.

The group of patients who repeatedly challenge the decisions of experts regarding disability is significantly less focused on restoring social statuses, as well as less focused on the ability to self-persuade positively, to plan for the future, has reduced willpower and external locus of control, lower discipline in treatment with low cognitive activity and interest in new medical and social technologies and opportunities for functional and social recovery.

Also, a radically different structure of coping competence was revealed in the studied groups.

We can see that behavioral and cognitive strategies dominate in the groups of people who do not consider themselves disabled, while emotional strategies in the structure of coping behavior mechanisms dominate in the group of expert patients who repeatedly challenge expert decisions. This is due to the fact that in the emotional cluster only one

strategy is adaptive such as Optimism, and for expert patients, as the study revealed, this strategy is not typical and used by them much more rarely than in the group of people who do not consider themselves disabled.

In the structure of coping behavior strategies, in the group of individuals who do not claim to be disabled, constructive strategies of "distraction," "altruism," "constructive activity," and "cooperation" prevail. In the group of individuals claiming disability, non-constructive strategies are much more often used: "self-isolation" and "escapism, withdrawal".

The comparison of values for cognitive coping strategies revealed that this cluster of strategies is most typical for people who do not claim to be disabled. The exception is the Religiousness strategy, the differences in the use frequency of which were not found (p=0,6901), and the Confusion strategy, which is more often used by individuals claiming to be disabled.

In general, the analysis of the results obtained for various clusters and coping mechanisms reveals a greater coping competence of a group of individuals who do not claim to be disabled. This is manifested in the use of adaptive strategies in all three clusters (behavioral, cognitive, and emotional) by individuals who do not claim to be disabled, which provide psycho-emotional regulation, cognitive self-action, and productive social activity of an individual suffering from a disease that requires a psychological resource to overcome a variety of emerging consequences. While the group of people who repeatedly claim to be disabled is mainly characterized by the use of emotional strategies of the maladaptive register "self-isolation," "escapism, withdrawal," "confusion," "suppression of feelings," "protest," "hopelessness," "pronounced aggressiveness," etc.

Conclusion

As a result of the study, the following conclusions were made:

1. The activity of people who do not consider themselves to be disabled is more adaptive and, in many ways, significantly differs from the activity of individuals claiming to be disabled.

2. Individuals who do not claim to be disabled are characterized by greater social activity, are more involved in the rehabilitation process, responsible for the treatment and show interest in finding various new rehabilitation methods and technologies, are socially active, and consciously use an adaptive repertoire of coping strategies against the background of the absence of negativism.

3. In the group of expert patients, there is a low rehabilitation adherence, a low level of coping competence, which serves as the basis for the inclusion of psychological rehabilitation measures to correct these maladaptive personal manifestations.

4. Considering all psychological risks in the methodology and organization of psychological rehabilitation measures is a condition for a successful rehabilitation

outcome since it is obvious that an individual who has psyched himself up to recovery is more likely to overcome the numerous difficulties caused by the disease (Scholten et al., 2018).

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