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Psychosocial determinants of disease acceptance in selected mental disorders

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Abstract

Introduction and objective. Every mental disorder may cause a number of negative consequences in the personal lives of the patients and their families as well as in their social relations. Acceptance of the disease is a crucial factor in the process of coping with the problems resulting from it. Acceptance of the disease may significantly influence the reduction of negative emotional reactions it causes. Consequently, it may contribute to better adaptation of the patients and hence may facilitate the process of recovery. The study attempts to define the socio-psychological conditioning of the degree of disease acceptance among patients treated for psychical disorders.

Materials and method. Opinion surveys were carried out in 2013 among a group of 240 patients treated in Mental Health Clinic in Chełm, eastern Poland. The study applied Acceptance Illness Scale – AIS B. Felton, T. A. Revenson, G.A. Hinrichsen, adapted in Poland by Z. Juczyński, as well as a socio-demographic questionnaire.

Results. The analysis of the obtained results revealed a similar level of acceptance of such diseases as anxiety disorders (24.41±8.52), depression (22.80±7.51) and personality disorders (23.89±7.89). The medical records of all patients fitted among the low average.

Conclusions. The greatest problem in the researched group related to the social consequences of the psychical disorders. Those questioned were afraid of the negative reactions of others and of being a burden to their families. The level of acceptance was not correlated with independent variables (age, gender, education, place of residence, general well-being).

Key words

socio-psychological conditioning, acceptance of illness, adaptation, mental disorder

INTRODUCTION

Determining the incidence of mental disorders seems to be extremely difficult since the data available offer merely a fragmentary view of the phenomenon, although it has been observed that the number of mentally-ill people who seek therapy has drastically increased [1, 2]. The number of patients treated in clinics increased from 980,000 to 1.4 million in the period 2000–2011. At the same time, the number of patients registered at Mental Health Clinics, addicted to alcohol and other substances in 2011 equaled 3,645 for each 100,000 inhabitants in Poland [1]. Among those, the most numerous were patients with neurotic disorders (901/100,000), mood disorders (699/100,000), and organic disorders (518/100,000) [1, 2].

Mental disorders and illnesses are conditioned by a complex set of mutually related biological, mental and socio-cultural factors [3, 4]. For this reason, diagnosis and therapy are often difficult to conduct. However, the patients require the help of a specialist, partly because mental disorders seriously affect all spheres of human life and may lead to suicidal attempts in extreme cases [5, 6].

A National Programme of Mental Health Care was adopted in Poland in 2011 in view of the dynamics, multilevel characters and consequences of mental problems. As part of the Programme, various forms of care and assistance necessary to function in everyday family and social environment are to be secured for patients with mental illnesses [7].

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Unfortunately, people still suffering mental problems often reject such diagnosis, delay therapy, or hide their state from others in fear of social reactions. This is due to the fact that for ages mental illnesses have been perceived through negative stereotypes. The latter are also the source of the society's anti-integrative attitudes towards the mentally ill and their families (prejudice, reservation, discrimination and stigmatization) [8, 9, 10]; therefore, mentally-ill people suffer from both the illness and marginalization. Furthermore, awareness of being ill and approval of the negative stereotypes associated with the illness undermine self-esteem, increase anxieties, deepen alienation of the ill, and are a serious obstacle on the way to accepting one's state and seeking help [11, 12].

OBJECTIVES

The study is an attempt to define the socio-psychological conditioning of the degree of disease acceptance among patients treated for psychical disorders.

MATERIALS AND METHOD

The questionnaire was voluntary and anonymous, and the research was conducted in 2013 among 240 patients of a Mental Health Clinic in Chelm, a city in the Lubelin Province in eastern Poland. From among the participants, 72 were diagnosed with neurosis, 130 suffered from depression, while the remaining 38 had personality disorders. The survey included, among others, socio-demographic information,

variables related to patients' treatment and situation, as well as the Acceptance of Illness Scale (AIS). The scale was developed in 1984 by B. J. Felton, T. A. Revensson and G. A. Hinrichsen at the Center for Community Research and Action, Department of Psychology at New York University. The Polish adaptation was compiled by Juczyński [13]. The AIS consists of eight statements referring to negative consequences of bad health concerning limitations imposed by the illness, self-insufficiency, dependence on others and low self-esteem. Each time, the patient had to assess to what degree a given statement was true for him/her. The task was completed using a 5-level scale: from 1 – I strongly agree, to 5 – I strongly disagree. Strong agreement (1) means insufficient adaptation to the illness, while strong disagreement (5) reflects illness acceptance. Overall illness acceptance is calculated from the total number of points and ranges from 8 – 40 points. Lower results (below 20 points) indicate strong mental discomfort as well as lack of acceptance of and adaptation to the illness. On the other hand, higher results (above 30 points) proved that the patient had accepted the illness and did not feel any negative emotions with regard to it. The psychometric AIS parameters were adequate. Cronbach's alpha, a coefficient of internal consistency, equals 0.85 for the Polish edition of the study and is close to that for the original one (0.82). As stated by the authors of the AIS, the scale is useful for assessing illness acceptance in various diseases and is meant to be used for ill adults [13].

The group of respondents suffering from mental disorders comprised 67.5% of women and 32.5% men. Their ages differed: young patients between 18 – 30 constituted 15% of the respondents, the middle-aged (31–50-year-old) – 39.2%, whereas the eldest (more than 51- -years-old) were most numerous (45.8%) of the total number of respondents. More than a half of the surveyed (55%) stated that they lived in small towns, fewer mentioned villages (24.2%) and big cities (20.8%). The study showed that most of the patients had secondary education (35.8%), fewer graduated from a vocational school (23.3%), while those with higher (15%), primary (17.5%) and a Bachelor's Degree (8,4%) education were least numerous. Assessment of respondents' own somatic health also varied: only 25% thought it was good, others described it as poor (51.7%), bad (18.3%) or very bad (5%).

RESULTS

Assessing the level of illness acceptance as well as mental well-being was based on data gathered by means of the AIS questionnaire. The average indicator of illness acceptance among the respondents was X=23.45 with standard deviation set at SD=7.85. 6 people (2.5%) obtained the lowest score (8 pts), while the top score (40 pts) was achieved by only 2 people (0.83%). Over one-third of the surveyed (36.6%, 88 people) obtained low scores which meant insufficient adaptation to the disease, whereas 20.8% of the respondents (50 people) obtained high scores and therefore accepted their illness. Most of the patients displayed an average level of illness acceptance (Fig. 1).

Analysis of the study results showed a similar level of illness acceptance in such mental disorders as anxiety (24.41±8.52), depression (22.80±7.51), and personality disorders (23.89±7.89). Differences between the groups were not statistically significant below 5%. Also, no significant relations were identified (r-Pearsona=-0.03) (Fig. 2).

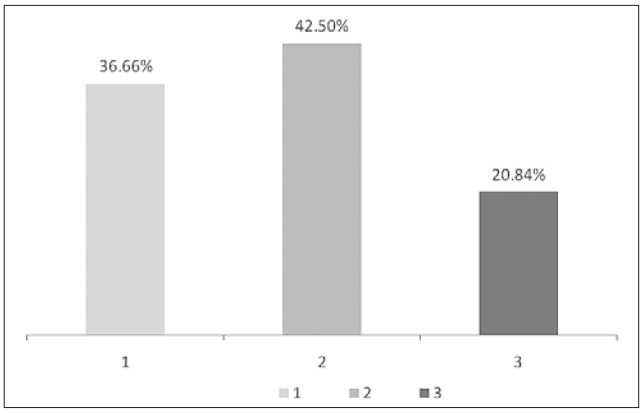

Figure 1. Illness acceptance among respondents
1 – <20 pts – low scores
2 – 2–30 pts – average scores
3 – <30 pts – high scores

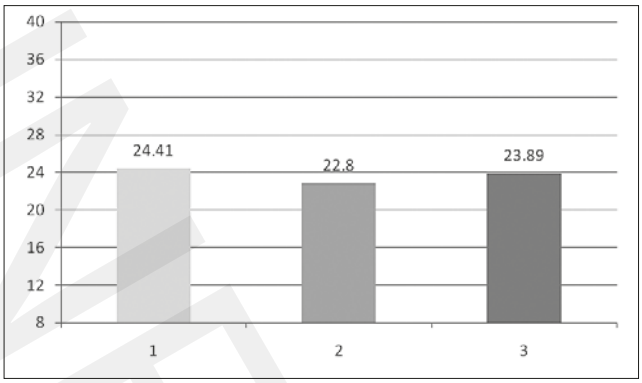

Figure 2. Average level of illness acceptance (AIS) in relation to diagnosis
1 – patients with anxiety disorders
2 – patients with depression
3 – patients with personality disorders

Moreover, no relationship was identified between the illness and gender (r-Pearsona=-0.41), age (r-Pearsona=0.14), education (r-Pearsona=0.09), place of residence (r-Pearsona=0.01) and physical well-being (r-Pearsona=0.23).

The next stage of statistical analysis tested whether the degree of illness acceptance was different for somatic and mental diseases. The analysis was carried out using the results of the authors' own studies [14] as well as those mentioned in the test adaptation manual [13] (Tab. 1). Results for illness acceptance were similar for patients with mental illnesses and those with chronic somatic diseases.

What followed was a detailed analysis of individual statements from the test. Average scores were calculated for

Table 1. Correlation of average illness acceptance (AIS) among patients with mental disorders as well as patients with selected chronic diseases.

	Mental disorders	Diabetes	Dialyzed patients	Ischaemic heart disease	Multiple sclerosis	Asthma
N	240	70	31	31	44	29
X	23.45	24.81	25.32	23.50	24.59	25.56
Sd	7.85	7.09	6.03	6.32	7.20	4.97
t		1.18	1.22	0.02	0.83	1.37
p		NS	NS	NS	NS	NS

Table 2. Averages and their order for individual AIS statements for patients with mental disorders.

	AIS statement	X	SD	Order No.
1	I have difficulties in adjusting to the limitations of the illness	2.49	1.25	6
2	Because of illness am unable to do what I would like to do	2.55	1.22	7
3	I sometimes feel unnecessary because of illness	2.49	1.27	6
4	Health problems make me more dependent on others than I would like to be	2.96	1.32	5
5	Because of illness I feel like a burden on family and friends	3.33	1.38	2
6	My illness makes me have low self-esteem	3.11	1.39	3
7	I will never be as independent as I would like to be	3.05	1.35	4
8	I think I embarrass people who are with me because of my illness	3.45	1.44	1

each statement, and then placed in numerical order. At one end there were the most problematic issues, at the other – those which scored most, i.e. not causing any problems for the mentally ill.

The social aspect of mental illnesses was a fundamental issue. The respondents were afraid of the reactions of others to their illness, and did not want to be a burden on their family and friends. Furthermore, the illness made them feel dependent on others and lacking in self-sufficiency. However, they did not regard their illness as a limitation (Tab. 2).

DISCUSSION

Certain adaptive mechanisms have to be activated when being faced with problems caused by the nagging symptoms of mental illnesses and various situations related to social perception of these. The mechanisms are supposed to help patients cope effectively in the new reality, and maintain the integrity of one's own self. Approval of life in the new, illness-shaped reality is also a part of adapting to the new situation. Acceptance of disease is thought to be an emotional indicator of functioning in illness and becomes evident in a slight increase in negative emotional reactions, as well as accepting the limitation caused by the illness [15]. Among the respondents, an average level of illness acceptance equalled X=23.45, with the standard deviation being SD=7.85. The scores of over one-third of the surveyed indicated a low level of illness acceptance. H. Marmurowska-Michałowska et al. obtained a comparable average score (X=24.70) for cooperative people with paranoid schizophrenia (i.e. those with documented treatment during the last 2 years) [16]. The results of people diagnosed with schizophrenia in the period of partial relapse, as observed by Bandura-Brzoza et al., were considerably lower (X=18±9) [17]. Although, it may seem that illness acceptance in mental diseases depends on the type of the disease, authors' own studies have not proved this thesis. Analysis of data obtained displayed a comparable level of illness acceptance in such diseases as anxiety disorders (24.41±8.52), depression (22.80±7.51), and personality disorders (23.89±7.89). Also, no relation was identified between illness acceptance and gender, age, education, place of residence and overall somatic well-being. The study also did not identify differences between the acceptance of a somatic and a mental disease. However, it is commonly observed that illness acceptance has a strong impact on the course of therapy and quality of patient's life [18]. Studies by Marmurowska et al. identified a positive correlation between illness acceptance and quality of the lives of people diagnosed with schizophrenia [16]. A comparable result was recorded by Poppe et al., who identified a similar correlation among highly neurotic patients [19]. The importance of illness acceptance was stressed when discussing strategies of coping with a mental illness [20, 21].

CONCLUSIONS

Acceptance of mental illnesses is a difficult task, partly because for many patients these lead to lowered self-esteem and social status. This has been reflected in the authors' own studies. Analysis of individual statements points to social consequences of mental disorders as a major problem. The respondents experienced self-stigmatization and were afraid of both society's negative reactions and being a burden on the family. A study of the literature shows that patients with diabetes identify with similar problems [22].

REFERENCES

1. Rocznik Statystyczny Rzeczypospolitej Polskiej (Polish Statistical Yearbook). Warszawa: GUS, 2012.
2. Moskalewicz J, Boguszewska L. Poprawa stanu zdrowia psychicznego Polaków. Diagnoza i rekomendacje (Improving the mental health of Poles. Diagnosis and recommendations). In: Szymborski J (eds.) Zdrowie publiczne i polityka ludnościowa. (Public health and social policy). Warszawa: Rządowa Rada Ludnościowa, 2012.p.101–109.
3. Brodniak WA. Społeczno-kulturowe uwarunkowania zaburzeń psychicznych. Próba syntezy (Socio-cultural conditions of mental disorders. Attempt of synthesis). In: Piątkowski W (eds.) Zdrowie, choroba, społeczeństwo. Studia z socjologii medycyny. (Health, illness, society. Studies in sociology of medicine). Lublin: UMCS, 2004.p.45–65.
4. Frąckowiak-Sochańska M. Zdrowie psychiczne kobiet i mężczyzn. Płeć społeczno-kulturowa A kategorie „zdrowia psychicznego" i „chorób psychicznych" (Mental health of women and men. Socio-cultural sex and the paradigms of „mental health" and „mental illnesses)." Now Lek 2011; 80: 394–406.
5. Kulikowska A, Jarocka I, Jakubów P, Ładny J, Wojewódzka-Żelezniakowicz M, Czaban S. Wybrane czynniki socjodemograficzne i kliniczne jako predyktory prób samobójczych ze szczególnym uwzględnieniem zatruć (Selected socio-demographic and clinic factors as predicators of suicidal attempts, with focus on poisoning). Post Nauk Med 2010; 9: 751–756.
6. Ho TP. The suicide risk of discharged psychiatric patients. J Clin Psych 2003; 64: 702–707.
7. Rozporządzenie Rady Ministrów z dn. 28 grudnia 2010 r. w sprawie Narodowego Programu Ochrony Zdrowia Psychicznego. Dz. U. Nr 24 z 2011 roku, p. 128.
8. Rüsch N, Angermeyer MC, Corrigan P. Mental illness stigma: concepts, consequences, and initiatives to reduce stigma. Eur Psychiatry 2005; 20: 529–539.
9. Dyduch A, Grzywa A. Stygmatyzacja i czynniki ją warunkujące na przykładzie stygmatyzacji związanej z chorobą psychiczną (Stigmatization and its conditioning as exemplified in stigmatization related to a mental illness). Pol Merk Lek 2009; 153: 263–267.
10. Gonzales-Torres MA, Oraa R, Aristegui M, Fernandez-Rivas A, Guimon J. Stigma and discrimi-nation towards people with schizophrenia and their family members. Soc Psychiatry Psychiatr Epidemiol 2007; 42: 14–23.
11. Jackowska E. Stygmatyzacja i wykluczenie społeczne osób chorujących na schizofrenię – przegląd badań i mechanizmy psychologiczne (Stigmatization and marginalization of schizophrenics – overview of research and psychological mechanisms). Psychiatria Pol 2009; 6: 655–670.

12. Corrigan PW, Watson AC, Barr L. The self-stigma of mental illness: implications for self-esteem and self-efficacy. J Soc Clin Psychol 2006; 25: 875–884.
13. Juczyński Z. Narzędzia pomiaru w promocji i psychologii zdrowia (Measurement tools in promotion and psychology of health). Warszawa: Pracownia Testów Psychologicznych PTP, 2001.
14. Niedzielski A, Humeniuk E, Błaziak P, Fedoruk D. Stopień akceptacji choroby w wybranych chorobach przewlekłych (Illness acceptance in selected chronic illnesses). Wiad Lek 2007; 60: 224–227.
15. Zawadzka B, Byrczek M. The formation of a temporal perspective as an aspect of adaptation to disease and treatment. Analysis based on studies of renal replacement therapy patients. Psychiatr Pol 2012; 46: 743–756.
16. Marmurowska-Michałowska H, Dubas-Ślemp A. et al. Przystosowanie do choroby w grupie pacjentów z rozpoznaniem schizofrenii paranoidalnej – doniesienie wstępne (Adaptation to illness among patients with paranoid schizophrenia – initial brief). Studies on Schizophrenia 2004; 5: 324–329.
17. Badura –Brzoza K, Piegza M, Błachu M, Ścisło P, Leksowska A, Gorczyca P. Ocena wpływu wybranych czynników psychicznych i socjodemograficznych na jakość życia pacjentów ze schizofrenią (Review of the influence of selected mental and socio-demographic factors onto the quality of schizophrenics' life). Psychiatr Pol 2012; 46: 975–984.
18. Cepuch G, Wojnar-Gruszka K, Kowalczyk M. Strategies for coping with pain presented by adolescents with hematopoietic malignancies. Folia Med Cracov 2012; 52: 71–82.
19. Poppe C, Petrovic M, Vogelaers D, Crombez G. Cognitive behavior therapy in patients with chronic fatigue syndrome: the role of illness acceptance and neuroticism. J Psychosom Res 2013; 74: 367–72.
20. Vilardaga R, Hayes SC, Atkins DC, Bresee C, Kambiz A. Comparing experiential acceptance and cognitive reappraisal as predictors of functional outcome in individuals with serious mental illness. Behav Res Ther 2013; 51:425–33.
21. Janowski K, Kurpas D, Kusz J, Mroczek B, Jedynak T. Emotional control, styles of coping with stress and acceptance of illness among patients suffering from chronic somatic diseases. Stress Health 2014; 30:34–42.
22. Lewko J, Polityńska B, Kochanowicz J. et al. Quality of life and its relationship to the degree of illness acceptance in patients with diabetes and peripheral diabetic neuropathy. Adv Med Sci 2007; 52: 144–146.