Original Article Pol J Public Health 2019;129(3): 82-86

KRZYSZTOF CHMIELOWIEC[1], ANDRZEJ KASPRZYCKI[2], ANNA GRZYWACZ[3], JOLANTA MASIAK[4], JOLANTA CHMIELOWIEC[1]

The level of the illness acceptance among patients of the Department of Alcohol Addiction Therapy

Abstract

Introduction. The illness acceptance is one of the most effective strategies to cope with a chronic illness.

Aim. The purpose of this study is to recognize which factors determine and favor acceptance of a chronic illness, in regard to the personal resources of alcohol-dependent patients.

Material and methods. The study was conducted on 60 alcohol-dependent patients. During the study, the following research tools were used: Rosenberg's SES questionnaire and AIS scale questionnaire.

Results and conclusions. The study group is characterized by an average level of acceptance of the disease. The level of self-esteem is an important factor in determining the level of acceptance of the disease in patients.

Keywords: illness acceptance, alcohol dependence, self-esteem, self-effectiveness.

DOI: 10.2478/pjph-2019-0020

INTRODUCTION

In 1951 the World Health Organization acknowledged alcoholism as a psychical and physical health disorder, however for years it had not been considered a disease but a social phenomenon, often negatively perceived by the society. The precursor of alcoholism as a nosological concept was E.M. Jelinek (1960). He classified the loss of control over the amount of drunk alcohol as a symptom of the disease [1]. He also introduced the concept of the alcoholism progression, in which he determined 4 phases. The first two phases – the pre-alcoholism stadium and the prodromal stadium represent the symptoms, while two further phases – the acute and chronic stadiums indicate the development of addiction. In the acute stadium there is the loss of control (a strong alcohol craving), in which an individual, despite having control over the time and circumstances in which he/she consumes alcohol, loses control over the amount. In this phase there is an apparent increase in alcohol tolerance. The chronic stadium is a progressive loss of control, which leads to the degradation of various aspects of life of an individual. This is accompanied by the decrease in alcohol tolerance and the increase in the physical need for alcohol which results in prolonged alcohol binges [2].

Another argument in favor of qualifying alcoholism as a disease is the possibility to determine the signs and symptoms of this disease[1], based on the research of Portnov, Piatnickaja (1976), which states that alcohol addiction may be characterized by specific and non-specific signs and symptoms of the disease. She determines the non-specific signs and symptoms as physical dependency, psychical dependency, and withdrawal syndrome which are characteristic of all the types of addiction to psychoactive substances. The specific signs and symptoms are tolerance, the style of drinking, psychical disorders, somatic diseases which are different in each kind of psychoactive substance addiction.

Alcohol addiction is a disease as it disturbs the homeostasis between health and disease. According to Woronowicz [3], in the biomedical context one could determine the physical factor of pathological changes in the body. The pathophysiological changes (disease) are the basis of psychological life, which means the way in which an individual experiences the disease (illness). In the sociological aspect (sickness), alcohol addiction certainly influences the functioning of an individual in relation to the surroundings, the way in which they fulfill the attributed tasks and life roles. The individuals addicted to alcohol are less able to satisfy their own needs and to cope with the requirements of everyday life.

Nowadays an addiction is considered to be a disease of "the brain", which eventuates from the results of the research indicating that the alcohol while influencing the neurological system, influences the brain as well. On the one hand, there are the disorders in the brain functioning which are constant no matter if an individual is currently drinking or if he/she is abstinent, on the other hand, there are also mechanisms that maintain the addiction which result in the limitation in the methods of the addiction treatment [3]. Therefore, alcohol dependence can be considered a chronic illness. Moreover, regarding the definition and criteria of chronic illness, alcohol dependence can be

[1] Department of Hygiene and Epidemiology, Faculty of Medicine and Health Sciences, Collegium Medicum, University of Zielona Góra, Poland
[2] Provincial Specialist Hospital for Nervously and Mentally Ill in Ciborz, Poland
[3] Independent Laboratory of Health Promotion, Pomeranian Medical University in Szczecin, Poland
[4] Neurophysiological Independent Unit, Medical University of Lublin, Poland

treated as such. One of the definitions of chronic illness states that "chronic illness is every permanent or long-lasting disease. It may progress slowly and lead to death or to full recovery. It may cause irreversible changes to the organs. Without a doubt it decreases the life quality of an individual" [4].

Every affliction which has the following features may be considered a chronic illness:

- it affects the functioning of various systems, resulting in the disruption of physical, psychical and social processes,
- it disrupts the natural course of life; its development lasts for many years, the majority of which are without visible signs and symptoms
- its course and development can be controlled but a complete recovery is impossible,
- gradually and imperceptibly it disrupts fulfilling various daily duties,
- the majority of them is characterized by a relatively gentle course, disrupted with remissions or dramatic, life-threatening complications [4].

The definitions of alcoholism as a disease emphasize its chronic character. Sęk [5] determines two different approaches to the essence of alcoholism: in the first one he considers alcoholism a chronic and irreversible disease, in the second one – a non-adaptable pattern of behavior of an individual. In 2011 the American Society of Addiction Medicine proposed the definition of addiction as a chronic and neurobiological disease of CNS, in the pathomechanism of which the functioning of processes of reward, motivation, memory and associated brain circuits play the crucial role [6]. Dysfunctions of those circuits lead to the characteristic biological, psychological, social and spiritual consequences. Through alcohol consumption, there appears a pathological feeling of a reward or relief and continuing alcohol consumption leads to addiction. Addicted individuals are incapable of consequent abstinence.

The current definition of alcohol dependence in Poland was created as a result of changes proposed by ICD 10. It changed the previous name "alcoholism" to "alcohol dependence". Alcohol dependence, according to ICD 10 (1992), is a sequence of physiological, behavioral and cognitive phenomena that previously had a greater value for the patient [7].

In order to identify the dependence, the identification of three or more signs and symptoms from the list below during the last year is required. Those are:

1. Alcohol craving – the urge to drink alcohol with the increasing emotional tension.
2. The impairment of the drinking control (the difficulty in controlling when to start and when to stop drinking, the difficulty in controlling the amount of alcohol consumed).
3. Physiological signs of withdrawal syndrome as a result of withdrawal or limitation of the consumed alcohol (tremor, nausea, vomiting, diarrhea, insomnia, increased sweating, sleeping disorders, loss of appetite disorders, cognitive processes disorders, visual and auditory hallucinations, delirium, seizures).
4. Change in alcohol tolerance – the increase or decrease, consuming larger amounts in order to obtain the expected effect.
5. Neglecting the alternative sources of pleasure and interests, the gradual concentration of life over the alcohol.
6. Drinking despite knowing about its harmfulness [7].

AIM

The aim of the study is to determine the level of acceptance of the disease with regard to the level of self-assessment among the individuals addicted to alcohol, treated in the Department of Alcohol Dependence Therapy in the Voivodeship Specialist Psychiatric Hospital SP ZOZ in Ciborz.

MATERIAL AND METHODS

In the study the following tools were used: to determine the level of self-esteem – Rosenberg Self-Esteem Scale – SES, Acceptance Illness Scale – AIS. Moreover, the study group was asked to fill in the metrics with the help of which, the following information was collected: age, sex, education, family, background, place of residence, the length of the disease and forms of received treatment.

Rosenberg Self-Esteem Scale – SES

Rosenberg Self-Esteem Scale – SES is a one-dimensional tool that enables one to verify the level of general self-esteem – relatively constant disposition understood as an aware attitude (positive or negative) towards "self". Rosenberg emphasizes that he considers high self-esteem as a belief to be "good enough" and valuable. Low self-esteem, according to Rosenberg, means dissatisfaction with oneself, rejecting oneself [8]. SES is composed of 10 diagnostic affirmatives. The patient's task is to indicate on the four-grade scale how much they agree with each of the statements. The possible results are between 10 and 40 points. The higher the result, the higher self-esteem. Psychometrically investigated individuals' Cronbach's alpha value for the Rosenberg Self-Esteem Scale was 0.78.

Acceptance Illness Scale – AIS

Acceptance Illness Scale – AIS is composed of eight statements, which describe the consequences of poor health. The authors used it as a part of an interview with the patient and it was to adapt to the disease. In each statement, the study participant rated its actual state according to a 5-stage scale, from 1 – "I fully agree", to 5 – "I fully disagree". A full agreement (grade 1) meant poor adaptation to the disease, while complete disagreement (grade 5) meant a disease acceptance. The sum of all of the points was the measure of an illness acceptance and its range was between 8 and 40 points. The low result meant the lack of acceptance and adaptation to the disease and a strong feeling of psychical discomfort. While a high result meant the acceptance of the condition which resulted in the lack of negative emotions in relation to the disease. Taking into consideration the mean standard deviation, three levels of the illness acceptance: 8-18 points – a low level, 19-29 points – an average level, 30-40 points – a high level [9]. Among the psychometrically examined patients, the Cronbach's alpha value was 0.84.

The characteristics of the study group

The study was conducted in 2019 in the Department of the Alcohol Dependence Therapy of the Voivodeship Psychiatric Hospital in Ciborz. The participants were informed by the therapists on the aim of the study. Only those who were diagnosed by a psychiatrist with the alcohol dependence according to ICD 10 classification, who gave informed consent and who underwent the treatment voluntarily participated in the study.

The total number of 60 patients participated in the study, the group consisted of 30 women and 30 men aged from 18 to 70 (M=44.7, SD=11.8). The youngest male participant was 25 years-old while the oldest – 64 years-old (M=43.6; SD=10.7). In the male group 50% of the participants were single, 24% were divorced, while only 20% remained in a relationship. In the female group most of the women (33%) were in a relationship, 30% had never been in a relationship, while 26% were divorced. Adopting the division of the study group into the individuals being in a relationship or single, in the study group 76% were single, 80% in the male and 67% in the female group.

Considering the professional status in the study group 47% of the participants were professionally active while 32 % remained unemployed.

In the study group 47% of women confirmed the alcohol problems in the family of origin (parents), while 23% in the current family system (a husband or partner). Only 20% of women denied the existence of the alcohol problem in the family, while in the male group 43% denied alcohol problems in the family. When it comes to 37% of the participants from the male group, they confirmed the alcohol problem in the family of origin (parents), while only 3% confirmed the alcohol problem among their wife or partner. In the age groups of 31-40, 41-50 and 51-60 years old, around 50% of the participants confirmed the alcohol problem among their parents. This percentage extends to 68% while the family of origin is extended to grandparents and siblings. In the study group 30% confirmed consuming alcohol for over 15 years, while for 28% it was between 5 and 10 years. In the male study group 46% confirmed consuming alcohol for over 15 years, while 27% estimated it to be between 5 and 10 years. This distribution is different in the female group from which only 13% confirmed consuming alcohol for over 15 years, while in the other ranges the distribution was similar and equaled to 29% each. Another criterion characterizing the study group was the forms of the undergone treatment. In the study group 25% had not undergone the addiction treatment before, the highest percentage of participants – 30% participated in the stationary therapy, those who combined it with other forms of treatment constituted 46%. The lowest percentage of participants were those who only underwent a pharmacological treatment – 2%, while combined with other forms of treatment the group extended to 8%.

Statistical methods

The obtained results were analyzed with the use of the 13.0 version of STATISTICA. Normal distribution hypotheses were verified with the use of the Shapiro-Wilk test (less numerous groups). The values of analyzed data were pictured with the use of descriptive statistics. The mean values (M), standard deviation (SD), minimal values (MIN) and maximal values (MAX), population (f) and percent (%). The relations between the analyzed variables were classified with parametric T-student test or ANOVA variation analysis.

RESULTS

In the study group, only 10% represented a low disease acceptance level, while 45% represented an average level of the illness acceptance and 45% represented a high level of illness acceptance (Table 2.). The mean value of the acceptance level in the study group was M=27.57 points, SD=7.33 (Table 1). The lowest level of acceptance in the study group referred to the statements regarding the adaptation to the limits imposed by the disease and the feeling of being unneeded.

TABLE 1. Descriptive statistics: AIS.

Variable	N	M	Min	Max	Bottom quartile	Upper quartile	Median	SD
Illness acceptance	60	27.57	10.00	40.00	23.00	33.00	28.00	7.33

TABLE 2. The division of the population into groups according to the level of the illness acceptance.

Variable	The level of acceptation	Incidence	Percent [%]
The level of the illness acceptance	8-18 points – low acceptance	6	10.00
	19-29 points – average acceptance	27	45.00
	30-40 points – high acceptance	27	45.00

The study group was divided into three groups according to the level of acceptance of the illness. The results were presented in Table 3.

The mean level of self-esteem in the study group was M=26.77; SD=3.64 (Table 3). It is lower than the normative mean, which has a value of 30.56 points. The most abundant group were the individuals with a low level of self-esteem – 30 participants (50%), the least abundant group were the participants with a high level of self-esteem – 7 participants – 11.70% (Table 4).

TABLE 3. Descriptive statistics: SES.

Variable	N	M	Min	Max	Lower quartile	Upper quartile	Median	SD
Self-esteem scale	60	26.77	17.00	35.00	25.00	29.00	25.50	3.64

TABLE 4. The division of the population according to the level of self-esteem.

Variable	The level of self-esteem	Frequency	Percent [%]
Self-esteem scale	10-26 points – low level of self-esteem	30	50.00
	27-31 points – an average level of self-esteem	23	38.30
	32-40 points – high level of self-esteem	7	11.70

Taking into consideration the fact that each study group is characterized by an average and high level of the disease acceptance, the values for consecutive quartiles were assumed to differentiate 4 groups differing in the level of the disease acceptance. The first group was those with low and average levels of the disease acceptance (between 8 and 23 points). The second group constituted those with an average level of disease acceptance. The third and fourth groups were the individuals with moderate and high levels of the disease acceptance within the range of 29-32 points (group 3) and 33-40 points (group 4).

Table 5. The differences in the variables: the self-esteem level, the feeling of self-effectiveness, the feeling of global coherence and the components: presumption, resourcefulness, reasonableness regarding the level of the illness acceptance.

Variable	Disease acceptation level				Variance analysis	
	Group 1. The low and moderately low level of illness acceptance (n=17)	Group 2. The average level of the illness acceptance (n=12)	Group 3. Moderately high level of the illness acceptance (n=14)	Group 4. A high level of illness acceptance (n=17)	F	P
Self-esteem scale	M=24.18 SD=2.88	M=25.75 SD=2.34	M=28.43 SD=3.13	M=28.71 SD=3.82	F(3.56)=7.723	**0.000**
The feeling of generalized self-effectiveness	M=28.06 SD=3.94	M=29.58 SD=2.47	M=31.85 SD=3.03	M=30.94 SD=4.54	F(3.56)=3.147	**0.032**

The results represented in Table 5 enable one to observe that the groups characterized by a different level of acceptance vary in the level of self-esteem, the feeling of coherence and its components. The participants of the study groups number 3 and 4 with the moderately high and high level of the illness acceptance (29-32 and 33-40 points) are characterized by higher self-esteem than the participants from the group 1 and 2, characterized by low and moderately low level of the illness acceptance (8-23 points and 24-28 points). The differences are statistically significant (p=0.000). The participants from groups 3 and 4 also represent a higher level of self-effectiveness, contrarily to groups 1 and 2. The differences in these groups are statistically significant (p=0.032). Examining differences in two comparable groups (post hoc) indicates that there are statistically significant differences in the level of self-esteem among the patients with low and moderately low illness acceptance (groups 1 and 2) and moderately high and high illness acceptance (groups 3 and 4). There are no statistically significant differences in the level of self-esteem in these groups (group 1 vs. 2 and group 3 vs. 4).

Post hoc tests indicated that there are statistically significant differences in the level of self-esteem and the level of general self-effectiveness between the participants with low levels of self-esteem (group 1) and the participants with a moderately high and high level of self-esteem (groups 3 and 4). Other differences in the mean value between the groups are not statistically significant. This enables one to state that individuals with low illness acceptance have a lower level of self-effectiveness in comparison to individuals with moderately high and high levels of illness acceptance.

The results indicate that individuals with a low and moderately low level of illness acceptance have a lower feeling of coherence in every aspect (understandability, resourcefulness, sensibility) in contrast to the individuals characterized by moderately high or high levels of illness acceptance.

TABLE 6. The differences in the level of variables: the illness acceptance, self-esteem scale, self-effectiveness, the feeling of coherence in the female and male groups.

Variable	Sex		Variance analysis	
	M (n=30)	F (n=30)	F	P
Illness acceptance	M=27.43 SD=5.99	M=27.70 SD=8.57	F(1,58)=0.020	0.889
Self-esteem scale	M=30.33 SD=3.85	M=26.50 SD=3.47	F(1,58)=0.318	0.575

The obtained results (Table 6.) indicate that women had a slightly higher level of the illness acceptance (M=27.70) in comparison to men (M=27.43), however with no statistical significance (p=0.889).

DISCUSSION

The problem of illness acceptance, especially in the context of chronic diseases, is the subject of a number of studies. The majority of the studies is related to somatic diseases. In the studies of Kurpas, et al. [10] the patients suffer from chronic neurological diseases, cardiological diseases or diabetes. The patients with nervous system disease had a mean illness acceptance level at 27.02 points which is close to the mean result in the study group. This may result from the fact that alcohol dependence is a psychiatric disorder. The patients diagnosed with diabetes had a mean illness acceptance value at the level of 25.7 points. In the study of Jankowska-Polańska, et al. [11], the level of illness acceptance among patients treated for hypertension had a similar distribution to the study group. As many as 41% of the interviewees presented a high level of illness acceptance, the average level of the illness acceptance was among 40% of the study group, while among 19% the level of the illness acceptance was low. Based on this study, it was concluded that the illness acceptance in the study group of alcohol dependent patients is at a high and average level (45% each). The mean acceptance value in the study group was 27.57 points and comparing the level of illness acceptance to other clinical groups, the level of the illness acceptance among people addicted to alcohol was average.

The results of the study indicate that there is a correlation between the level of acceptance and the level of personal resources such as self-esteem scale and the level of self-effectiveness. The results show that the level of self-esteem was on a low and moderate level. When it comes to 50% of the participants of the study, they had low level, while 39% had an average level of self-esteem. The mean level of self-esteem in the study group was 26.77 points. Low self-esteem is associated with feeling powerless and with believing to be worse than everyone else. The person notices the differences in who they are (the real self) and who they wish to be (the ideal self). They are negative towards themselves, the environment and the emotions such as sadness, fear and affliction dominate. Low self-esteem means the lack of belief in one's own power, dissatisfaction with oneself, which makes it unable for the sick person to pursue the program of change.

The results of this study indicate that the patients in the study group addicted to alcohol were characterized by a high level of self-effectiveness. The mean generalized self-effectiveness in the study group was M=30.07 and was higher than the mean of a normalized group (M=27.32). In clinical groups the highest mean value was among women after mastectomy and it was at the same level as that in the study group. In the study of Basińska in the group of patients with type 1 diabetes the mean value of self-effectiveness was M=29.63, among the patients with renal insufficiency M=25.56, with bronchial asthma M=29.46, with psoriasis M=27.46 [12]. As the results

of the studies show in chronic illnesses such as asthma, diabetes and cardiac infarction, the feeling of self-effectiveness is a mediator in relation to influencing health, it prevents negative mood and deterioration of psychical and physical condition [13]. Statistical analysis of this study shows that both in the case of self-esteem and self-effectiveness in the study group men were characterized by a higher level of self-esteem (30.33) than women (M=26.50), similarly, in the case of the level of self-effectiveness men had a higher mean value (M=30.33) than women (M=28.90). At the observed level of the illness acceptance, a high level of self-effectiveness in the study group may indicate that the variable is a strong predictor of the illness acceptance in the group of the addicted to alcohol. It could be assumed, knowing that the level of self-effectiveness did not correlate with the level of the illness acceptance, that a low level of self-esteem was compensated by a high level of self-effectiveness. The addicted patients, in the concept of Melibruda in the mechanisms supporting the disease process, often present an inadequate (bipolar) view of oneself. The results obtained in this study may in part be a reflection of the mechanism of a scattered, split self.

The level of the illness acceptance was similar in the group of men and women and was about 27.75 points. In the studies of patients with various diseases – among cardiological patients, patients with bronchial asthma, psoriasis, there were no differences in the illness acceptance between men and women [14]. The results of this study indicate that the age of the patients was what differentiated the study group. The patients aged up to 46 years accept their illness less (M=27.45) than older patients (M=27.86). In the studies of the patients with unstable angina, the age of the participants had a strong influence on the level of the illness acceptance. According to Fedoruk's studies, it could be concluded that the highest level of the acceptance was in the group of patients up to 50 years old, while the patients in the following age ranges had a lower level of the illness acceptance [15]. The next factor influencing illness acceptance is how long it lasts. The studies indicate that the longer the disease, the lower level of the illness acceptance. The previously mentioned results of the studies of Fedoruk [15] indicate that people suffering from unstable angina for up to 4 years had a higher level of illness acceptance than the patients in other time groups. The poorest results were among the patients suffering from the disease for more than 20 years. The differences were statistically significant. In this study the ones suffering from the disease for 5 years or less presented a higher level of acceptance than those suffering from the disease for 5-10 years or 10-15 years. The highest level of illness acceptance was among those suffering from the disease for more than 15 years. The differences in the illness acceptance between those groups were not statistically significant.

The result of this study indicates as well that the level of the illness acceptance differentiated the level of all the analyzed personal resources. The results were statistically significant in all the analyzed personal resources. The patients with moderately high and high illness acceptance are characterized by a higher level of self-esteem and general self-effectiveness than those with moderately low and low levels of illness acceptance. Those results were statistically significant.

REFERENCES

1. Cierpiałkowska L. Alkoholizm – przyczyny, leczenie, profilaktyka. Poznań: Wydawnictwo Naukowe Uniwersytetu im. Adama Mickiewicza w Poznaniu; 2001.
2. Cierpiałkowska L. Psychologia uzależnień alkoholizm. Warszawa: Wydawnictwo Akademickie; 2010.
3. Woronowicz BT. Uzależnienia – geneza, terapia, powrót do zdrowia. Warszawa: Parpamedia; 2009.
4. Ziarko M. Zmaganie się ze stresem choroby przewlekłej. Poznań: UAM; 2014.
5. Sęk H. Wprowadzenie do psychologii klinicznej. Warszawa: Wydawnictwo Naukowe Scholar; 2007.
6. http://www.asam.org/quality-practice/definition-of-addiction/ dostęp daty
7. Pużyński S, Wciórka J. Klasyfikacja zaburzeń psychicznych i zaburzeń zachowania w ICD 10 Instytut Psychiatrii i Neurologii; 2000.
8. Łaguna M, Lachowicz-Tabaczek K, Dzwonkowska I. Skala samooceny SES Morrisa Rosenberga – polska adaptacja metody. Psych Społ. 2007;2:164-76.
9. Juczyński Z. Narzędzia pomiaru w promocji i psychologii zdrowia. Warszawa: Pracownia Testów Psychologicznych PTP; 2009.
10. Kurpas D, Kusz J, Jedynak T, et al. Stopień akceptacji choroby przewlekłej wśród pacjentów. Fam Med Prim Care Rev. 2012;14(3):39-8.
11. Jankowska-Polańska B., Wleklik M. Wpływ akceptacji choroby na jakość życia chorych z nadciśnieniem tętniczym. Nadciśn Tętn. 2014;18(3):143-50.
12. Basińska MA, Kasprzak A. Związek między strategiami radzenia sobie ze stresem a akceptacją choroby w grupie osób chorych na łuszczycę Przegl Dermatol. 2012;99:692-700.
13. Juczyński Z, Ogińska-Bulik N. Zasoby osobiste i społeczne sprzyjające zdrowiu jednostki. Łódź: Wydawnictwo Uniwersytetu Łódzkiego; 2003. p.63-77.
14. Andruszkiewicz A. i wsp. Brak tytułu artykułu. Probl Pielęg. 2014;22(2):239-45.
15. Fedoruk D. Poziom akceptacji choroby przez pacjentów w wybranych chorobach wewnętrznych. Wydawnictwo: UM w Lublinie; 2006.

Corresponding author
Dr Krzysztof Chmielowiec
Department of Hygiene and Epidemiology
Faculty of Medicine and Health Sciences
Collegium Medicum, University of Zielona Góra
28 Zyty St., 65-046 Zielona Góra
E-mail: k.chmielowiec@wln.uz.zgora.pl