Attitude to the Diseases of the People with Different Health Levels

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Abstract

We have suggested that the most marked level of defense from the diseases could be both in people with good health and people with chronic diseases. The most adequate attitude to the diseases could be in people who are on the board between health and chronic diseases. 3 groups of subjects participated in the research (from 17 till 40 yr.): people with good health, the participants with some functional deviations without any chronic diseases, those who had some chronic disorders. The survey of the attitude to the diseases; screening scale of the behavior styles during the treatment; Hardiness Survey were used. The participants of the first and the third groups actively denied the thoughts about diseases. Our hypothesis was supported.

Keywords: attitude to disorders, health, behaviour style, hardiness

1. Introduction

A lot of people now know how to keep the health but do nothing to support it (Nikolaeva and Merenkova, 2013). It looks like they have special defense mechanisms from the diseases (Nikolaeva, 2010). What kind of people is more ready for health supporting and forming? We have suggested that the most marked level of defense from the diseases could be in people with good health and people with chronic diseases. We suppose this possibility because of the first group of people have never the experience of chronic illness, but the second one have already got accustomed to illness and lose the feeling of its danger. The most adequate attitude to the diseases could be in people who are on a board between health and chronic diseases. In Russia now the typical diseases’ prophylaxis methods is the informing about the consequences of unhealthy behavior and demonstration methods of health supporting behavior (Nikolaeva and Merenkova, 2013). In compliance with the theory of planned behavior it is possible to predict behavior changing with the intention to perform specific behavior (Ajzen, 1991). But the
intention in turn is determined by subject’s attitude (positive or negative) to the behavior, subjective norms (subject’s representations about the expectations of important others to behave this way) and perceived behavioral control (subject’s representations about is it easy or not to change the behavior in new direction). The author of this theory thought that just last component is the strongest predictor of the behavior changing. It is possible to propose that people who have never been ill could think that it is easy to change the behavior, but those, who have chronic diseases for a long time could think that it is impossible to change behavior. Just those people who experience the beginning of the severe diseases could hope to change the situation with changing their behavior. The purpose of our investigation was to describe the attitudes to the diseases of people of three health groups: healthy people (the first health group), people with some symptoms of chronic diseases (the second group) and people with chronic diseases (the third group).

2. Materials and methods

All the subjects were divided on three groups: healthy people (the first group, 17 subjects, 17-32 years old), people with some symptoms of chronic diseases (the second group, 15 subjects from 17 till 34 years old) and people with chronic diseases (the third group, 18 subjects, 17 - 40 years old). Total quantity was 50 subjects.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Health groups</th>
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<tbody>
<tr>
<td></td>
<td>1 (healthy people)</td>
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<tr>
<td>Age</td>
<td>21.8±4.2</td>
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We have used the survey of the attitude to the diseases -TOBOL (Vasserman, Iovlev, Karpova and Buks, 2005); screening scale of the behavior styles during the treatment (Urvanzev, 1993); Hardiness Survey of Maddy (Leontjev and Rasskasova, 2006) adapted by Leontjev and Rasskasova (Maddi, 1997). TOBOL survey described 12 types of attitude to the diseases: sensitive, anxious, hypochondriac, melancholic, insensitive, neurasthenic, egocentric, paranoiac, anosognostic, dysphoric, ergopathetic and harmonious. All them are combined in three blocks using 2 criterions: «adaptability – dysadaptability» (the influence the attitude to diseases on the patient’s adaptation), «inter–intrapsychical intentions of dysadaptability (if dysadaptability is found out). The first block includes harmonious, ergopathetic and anosognostic types of attitude to diseases. For these types psychical and social adaptations are not broken essentially. Patients with harmonious type asses their state sufficiently, active participate in treatment of disease, maintain the doctor’s prescription and strive for recovery. Patients with ergopathetic and anosognostic types of attitude to diseases are less critical to their state, could deny it’s seriousness, but there are no any signs of imbalance of psychological and social adaptation. Two other blocks include people with psychic adaptation imbalance. The second block includes attitudes with intrapsychical direction on the disease appearance and the third – with extrapsychical one. Screening scale of the behavior styles during the treatment (Urvanzev, 1993) reveals three styles: high level of confidence to medical stuff and passivity during treatment; middle level of confidence to medical stuff, activity in the treatment process and self-dependence; low level of confidence to medicine, criticality and antagonism against collaboration with medical stuff. The last method we used was Hardiness Survey of Maddy (Leontjev and Rasskasova 2006). adapted by Leontjev and Russkasova (Maddi, 1997). It was shown earlier that hardiness could influence on diseases initiation and decrease of activity effectiveness (Maddi, Harvey, Khoshaba, Lu, Persico & Brow, 2006). Hardiness is the system of representations about oneself, world and the interrelationships with world and others. It includes three components: involvement, control, risk’s acceptance. Hardiness from one side influences on the situation assessment, from the other side, it promotes to overcome the difficulties. It activated health behavior.

3. Results

Participant’s data were differed just for the survey of the attitude to the disorders. We have found out that the data for the health participants and participants with chronic diseases have no any differences on the scales of this survey and differed for the results of the second group. The participants of the first and the third groups had anosognostic type of attitude: they actively denied the thoughts about disorders. Our hypothesis was supported. This result shows that we need to form conscious attitude to health and to disorders.
It is shown that there are no any differences between attitudes to diseases of healthy and chronically ill people. These people had identical set of attitude’s type: anosognostic, ergopathic and harmonious. But anosognostic and ergopathic are predominant ones and just 20% of the subjects each group had harmonious type (Fig. 1).

Anosognostic type of attitude to diseases is characterized with denial of disease, unwillingness of thinking about its consequence. Ergopathic type is characterized with going away from the special information, “immersion in work”. But the subjects of the second group have low levels of anosognostic and ergopathic types. In this group is the same quantity of people with harmonious type and there are no any predominant types of attitude. But there are people with dysadapation due to disease development. There is the tendency of the decreasing of hardiness level in subjects of the second group as compared with subjects of two other groups and they more often have emotional changing: dysphoric, anxious and hypochondrical type of attitudes. The disease beginning needs from subject having a lot of plans to change the behavior and restrict the plans. Undoubtedly this information could influence on the emotional sphere of the patients. At this moment they try to find the information and hope to recover with changing their behavior. Those people with chronic diseases just have the experience both in treatment and in trying to change the behavior. Most of them have known the impossibility to recover. They prefer to ignore the disease, but their hardiness is the highest one. They have changed their aims. The theory of planned behavior helps us to understand the differences in attitude to the diseases, but it does not explain differences in hardiness of people of different group.

The concept of the “inner disease picture” (Luria, 1977) describes the patients’ representations about their disease, understanding the course of it, consequence for human being, the possibility of the stuff to help. This is complex inner sensations, perceptions, emotions, affects, conflicts, traumas. There are four levels of inner disease picture:

1) perceptual, that is the set of the painful sensations;
2) emotional, that is experience of disease and its consequences;
3) intelligent, that is knowledge about disease and its assessment;

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Table 2. Parameters of the subjects of different groups (mean and standard deviation, scores)

<table>
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<tr>
<th>Parameters</th>
<th>Health groups</th>
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<tbody>
<tr>
<td></td>
<td>1</td>
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<tr>
<td>Level of hardiness</td>
<td>88.3±15.2</td>
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<tr>
<td>The behavior styles during the treatment</td>
<td>1.4±0.6</td>
</tr>
<tr>
<td>Attitude to the diseases</td>
<td>5.6±1.9</td>
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* indicates differences between parameters of the 2 and 1 group; and 2 and 3 groups, p≤0.05 (T-criterion).

Fig. 1. The subject’s distribution on the types of attitude to the diseases
4) motivational, that is elaboration of the certain attitude to the disease, behavior changing, activity aimed at the recovering.

This concept supposes that motivation is the most important part of patient’s inner representations. But motivation differs for people of different groups. We think that just stage-based model of behavior changing could help us to understand the difference in hardness level of subjects’ different groups. There are some models which consider the behavior as a process that occurs through a series of different stages (Bridle, Riemsma, Pattenden, Sowden, Mather, Watt & Walker, 2005). The difficulties people face in trying to change their behavior differ at different stages in the changing process (Cialdini, Reno and Kallgren, 1990). That is people describe their disease and the possibility to recover different way on the different stages. The number of stages varies between models. But all of its makes out three mandatory stages with three types of people which correspond with our three groups: those who have not yet decided to change the behavior; those who have decided (but do not try); those who already engaged in the process of changing their behavior. The most known stage-based model is transtheoretical one (Prochaska and Velicer, 1997). It includes 5 stages with five types of individuals:

- precontemplation – the stage on which subject has no intention to change his (her) behavior during next 6 months;
- contemplation – the stage on which subject intends to change his (her) behavior in the nearest future (during next 6 month);
- preparation – the stage on which subject takes steps to change his (her) behavior;
- action – the stage on which target behavior has been modified for less 6 months;
- maintenance – stage on which the target behavior is keeping on.

It is supposed that there is the progress from earlier stage to later one, but relapse to an earlier stage can occur. It is proposed that the effectiveness of the process of changing varies according to the people readiness to change (Prochaska and Velicer, 1997). We could summarize that the highest level of hardness of the subjects with chronic diseases can be explained as the readiness of these people to solve different problems. And the lowest level of hardness of people of the second group is explained with the lack of the experience of the struggle against the severe diseases.

4. Conclusions

We have shown that the data of the groups were differed just for the survey of the attitude to the disorders. It was found out that the data for the health participants and participants with chronic disorders have no any differences on the scales of this survey and differed from the results of the second group (with some symptoms). The participants of the first and the third groups had anosognostic and ergopathyc types of attitude to the diseases: they actively denied the thoughts about their states. The subjects of the second group have no any predominant types of attitude. But there are people with dysadaptation due to disease development. There is the tendency of the decreasing of hardness level in subjects of the second group as compared with subjects of two other groups and they more often have emotional changing: dysphoric, anxious and hypochondrical type of attitudes. Theory of planned behavior and transtheoretical model could explained the different levels of hardness in three groups and the similarity of the attitude to diseases of healthy people and people with chronic diseases.

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References


