The effect of acceptance on health outcomes in patients with chronic kidney disease

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Abstract

The concept of acceptance has both research and clinical significance. There may be two types of acceptance leading to different health outcomes. By assessing their level and type of acceptance, clinicians could provide patients with appropriate treatments to encourage ‘active’ acceptance, thereby leading to positive health outcomes.

Keywords: chronic kidney disease; depression; health status; psychological factors; quality of life

To improve clinical outcomes of patients with chronic kidney disease (CKD), there has been increasing research on the impact of individual psychological processes and social environment factors (known as psychosocial factors) on the CKD population [1–3]. Psychosocial factors are shown to significantly contribute to the overall health outcomes, for example, by alleviating patients’ perception of their disease burden, enhancing their rehabilitation [1, 4, 5], as well as helping to explain the proportion of variance in their quality of life (QoL) and level of depression [2, 3].

The Poppe et al. study [6], published in the current issue of Nephrology Dialysis Transplantation, contributes to this growing body of research by demonstrating the effects of psychosocial factors on the health outcomes of patients with CKD. Their study focuses on the role of acceptance in patients’ health-related QoL (HRQoL) and the effect of neuroticism on acceptance. With cross-sectional data from 99 patients with CKD and on mixed treatment modalities (including pre-dialysis, dialysis and transplant) as well as the use of path analysis, Poppe et al. [6] examined the direct and mediating effects of acceptance and the direct
effect of neuroticism on the physical and mental health of these patients, measured by the SF-36 Health Survey. Their results show that acceptance has a medium direct effect on physical health and a small direct effect on mental health, using Cohen’s guidelines [7], and that neuroticism has both a medium direct effect and a small indirect effect mediated by acceptance on mental health. These results support their hypothesized effects of acceptance and neuroticism on HRQoL of patients with CKD. Accordingly, Poppe et al. [6] suggest early psychological assessment for patients with CKD and the introduction of treatments potentially facilitating acceptance and addressing personality issues.

Acceptance (also known as illness acceptance) has been widely discussed in the theoretical models of adaptation to chronic illness and disability (CID) [8], and the literature of rehabilitation psychology [8, 9] and health psychology [10]. It has also been identified as one of the important factors for psychosocial adaptation in end-stage renal disease [11].

The concept of acceptance, originating from the literature of loss and grief, has been one of the essential elements in the psychosocial adaptation to CID. In the early decades, acceptance was conceptualized in the context of loss and examined by loss-oriented measures (e.g., acceptance of disability scale) [12]. It was also conceptualized as a state patients with CID arrive at in a stage model where the early stage is denial and the final stage is acceptance. Later, it was seen as an adaptive task or coping strategy and was measured by questionnaires such as the COPE questionnaire and Illness Cognition questionnaire. By accepting the CID, patients are expected to focus on coping with its impact. The coping tasks may include incorporating CID into their life routines, changing their value systems and goals, as well as continuing to pursue important goals. This conceptualization of acceptance appears in Poppe et al’s study [6] with a significant emphasis on adaptive coping. More recently, acceptance has been defined as an experiential process in the context of Acceptance and Commitment Therapy: a moment-to-moment engagement. Their results suggest that acceptance is the precursor to adaptive coping. Chan et al. [4] examined the role of acceptance together with other psychosocial factors in the adaptational process of long-term dialysis patients. When all psychosocial factors are allowed to correlate with each other in the path-analysis model (thus their intercorrelations are explained in the model), the effect of acceptance on the psychological state diminishes significantly. These results may suggest that the effect of acceptance can be better accounted for by other psychosocial factors or that acceptance may not be important to patients who have been on dialysis for long time. Other recent studies [27] show that acceptance only becomes a significant factor in early dialysis patients (who have been on dialysis for ≤14 months), but not in both pre-dialysis (patients with estimated glomerular filtration rate ≤30 ml) and long-term dialysis patients. These results suggest that the effects of acceptance may not be universal across the course of disease and treatment and may be more important in some stages of disease and treatments than others. Moreover, if both negative and positive affects as well as QoL are included in the analysis, acceptance tends to load onto the negative affect rather than onto the positive affect or QoL. This may suggest that acceptance of illness and treatment would only help reduce patients’ negative affect but would not change their positive affect or QoL.

Very few studies have examined the concept of acceptance in the CKD literature. Studies on the role of acceptance, thus far, mainly examine patients on renal replacement therapies. In early studies, acceptance was shown to be related to locus of control [23] and was identified as one of the coping strategies for stress in haemodialysis patients [24]. Keogh and Feehally [25] found that the level of acceptance is shown to be higher among transplant patients than dialysis patients, and is related to demographic characteristics, such as age and ethnic background and transplant failure. In their model of adaptation to CKD, Wright and Kirby [11] argued that during the process of adaptation, acceptance is a core construct and may be classified into three main components, namely emotional, behavioural and cognitive. Patients accepting their illness would show positive emotions, limited negative thoughts about illness and treatments and adaptive behaviours. The importance of acceptance in the adaptational process is that when individuals acknowledge the existence and permanence of their illness and are willing to incorporate it into their identity, they are more likely to perform appropriate adaptational behaviours.

More recently, Gillanders et al. [26] found that acceptance measured as a coping strategy is correlated with increasing use of adaptive coping strategies, such as positive reframing, forward planning, humour and decreasing use of maladaptive coping, such as behavioural disengagement. Their results suggest that acceptance is the precursor to adaptive coping. Chan et al. [4] examined the role of acceptance together with other psychosocial factors in the adaptational process of long-term dialysis patients. When all psychosocial factors are allowed to correlate with each other in the path-analysis model (thus their intercorrelations are explained in the model), the effect of acceptance on the psychological state diminishes significantly. These results may suggest that the effect of acceptance can be better accounted for by other psychosocial factors or that acceptance may not be important to patients who have been on dialysis for long time. Other recent studies [27] show that acceptance only becomes a significant factor in early dialysis patients (who have been on dialysis for ≤14 months), but not in both pre-dialysis (patients with estimated glomerular filtration rate ≤30 ml) and long-term dialysis patients. These results suggest that the effects of acceptance may not be universal across the course of disease and treatment and may be more important in some stages of disease and treatments than others. Moreover, if both negative and positive affects as well as QoL are included in the analysis, acceptance tends to load onto the negative affect rather than onto the positive affect or QoL. This may suggest that acceptance of illness and treatment would only help reduce patients’ negative affect but would not change their positive affect or QoL.

Poppe et al’s study [6] provides further support to the importance of acceptance at different stages of CKD and shows that acceptance is a mediator to other psychosocial factors. However, three issues remain. First, as suggested in previous studies, the relationship between personality and acceptance may be a correlated rather than mediating one. It would clarify their relationships more if alternative models were tested in the path analysis, for instance,
allowing a correlation between personality and acceptance in the model. Second, the mediating effects of the time of diagnosis and commencement of dialysis on acceptance require further examination. It is not unreasonable to assume that acceptance matters more to patients with a recent diagnosis of CKD or who have just commenced dialysis than those who have CKD or have been on dialysis for long time. A prospective study may shed more light on this issue. Finally, the mediating effects of treatment modality require further investigation. Previous studies show that the effects of acceptance vary between treatment modalities. Thus, separate analysis of the effects of acceptance on each treatment modality or analysing treatment modality as a mediating variable to acceptance may help clarify its impact.

The literature thus far suggests positive effects of acceptance in both dialysis and patients with CKD, consistent with the commonsense that one has to accept what is happening before one can initiate coping. Conversely, acceptance may not be all positive. Other researchers have found that ‘realistic’ (realistic acknowledgement of one’s deteriorating condition and eventual death [28]) or ‘stoic’ (acknowledgment of the diagnosis without further inquiring [29]) acceptance may be related to negative outcomes, such as hopelessness and decreased survival time in people with acquired immune deficiency syndrome [28, 30], decreased survival time in women with breast cancer [29, 31, 32] and in people with other types of cancer [33–35]. These findings suggest that simply accepting the situation may not necessarily lead to positive outcomes, on the contrary, it may cause negative results.

To reconcile the conflicting findings on the effects of acceptance, it is important to note the differences in the definition and operationalization of two types of acceptance [36]. The acceptance, leading to better outcomes, is ‘an acceptance with optimism and active living’ (also ‘active’ acceptance [36]), contrary to the acceptance, leading to negative results, as ‘an acceptance with pessimism and passivity or non-living’ (also ‘realistic’, ‘stoic’ or ‘resigning’ acceptance [36]). ‘Active’ acceptance includes both components as previously defined in this article: (i) acknowledgement of the negative experiences without dysfunctional controlling mechanisms and (ii) restoration of a sense of living by integrating the illness into everyday living whilst pursuing important goals or values. ‘Resigning’ acceptance includes the first component yet coupled with passive behaviours, negative cognitions and affects. It seems that acceptance is important but actions that follow are even more important. Nakamura and Orth [36] found the two distinct constructs of acceptance and concluded that ‘active acceptance is associated with a generally positive outlook and with constructive efforts to shape one’s life; in resigning acceptance… an individual gives up and turns away from the situation’ (pp. 289). Nevertheless, there remain many questions about the effects of acceptance. Nakamura and Orth raised a question whether ‘active’ acceptance and ‘resigning’ acceptance are sequential or distinctive. This leads to further questions whether there is a magnitude in acceptance; whether acceptance is a static phase or one can change from one type of acceptance to another; whether the type of acceptance may shift with the course of illness and treatments, for instance, one may adopt ‘resigning’ acceptance when it is first diagnosed and shift to ‘active’ acceptance as time goes by; and whether acceptance should be conceptualized as a coping strategy, a stance or a process. If the two component definition of acceptance is adopted, one may question whether the two components can be studied separately and whether patients can achieve the first component and not the second. More importantly, future research on CKD may examine the associations between ‘active’ acceptance and health behaviours, such as dialysis compliance, between acceptance, QoL and psychological states (depression, stress and anxiety), the impacts of ‘resigning’ acceptance, and other confounding factors on the effects of acceptance.

Patients’ acceptance of CKD and/or dialysis is relevant and important in the clinical setting, as the ‘active’ acceptance tends to lead to favourable health outcomes, such as reduced levels of depression, reduced maladaptive coping, improved adaptive coping, improved QoL and improved psychosocial adaptation. The literature thus far suggests that clinicians may want to assess the type of acceptance patients engage in by asking additional questions about what patients may do after accepting their illness. Clinicians may also be more alert to the patients’ level of acceptance at the time of the initial diagnosis and commencement of dialysis. When patients engage in ‘active’ acceptance, clinicians may want to encourage their adaptive coping. When non-acceptance or ‘resigning’ acceptance is found, patients may benefit from psychological interventions.

There may be two groups of therapeutic strategies for improving acceptance, namely cognitive behaviour therapy (CBT) and acceptance and commitment therapy (ACT) [13]. In the CBT perspective, Sperry [37] proposes to first revise the patients’ negative and sometimes inadequate illness perceptions and/or representations by providing them with adequate and realistic information. Second, spouses and/or families of patients may need to help acknowledge the existence and permanence of patients’ illness, and the resultant changes. Finally, the patients are assisted in processing their grief over the loss of pre-illness identity and lifestyle.

In the ACT perspective [13], non-acceptance is a form of cognitive and behavioural avoidance and resistance. Ongoing non-acceptance can result in permanent suffering. To improve acceptance and reduce avoidance and resistance, strategies would involve increasing awareness of suffering caused by non-acceptance through experiential exercises, and reducing resistance and avoidance through cognitive diffusion and mindfulness exercises. Eventually, individuals are assisted in approaching life by setting goals based on individual values and committing themselves to actions, despite the existence of unpleasant situations, such as illness, pain and negative emotional states.

The concept of acceptance has both research and clinical significance. There may be two types of acceptance leading to different health outcomes. By assessing their level and type of acceptance, clinicians could provide patients with appropriate treatments to encourage ‘active’ acceptance, thereby leading to positive health outcomes.
Conflict of interest statement. None declared.


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Received for publication: 15.5.2012; Accepted in revised form: 2.6.2012