Int. j. pathol 2014; 12(1): 16-23

Original Article

Social Dysfunction in Patients with Chronic Illness

Hamid Rashid Khawaja*, Muneeza Hamid**
*AIMS,** AJKMC, Muzaffarabad.
Kashmir Surgical & General Hospital, Muzaffarabad

Abstract

Background: Social dysfunction refers to an undesirable behavior pattern or disturbed social interaction, performance, self-perception and self-system which results in decreased self-care and increased distress in the life of individual. Chronic illness is the major reason behind social dysfunction. Both, the psychiatric chronic illness (depression, anxiety, psychotic disorders) and non-psychiatric chronic illness (diabetes, stroke, heart disease etc.) can lead to social dysfunction.
Objectives: The study has been carried out for the purpose of exploring the level of social dysfunction among patients with chronic illness and to analyze the demographic factors associated with it.
Methodology: A total number of 300 patients of chronic illness were selected from psychiatric and medical OPDs of Abbas Institute of Medical Sciences (AIMS) Muzaffarabad using purposive sampling technique. Socio-demographic data was collected and then a 21-item standard scale of Linn (social dysfunction rating scale) was used to measure the social dysfunction of patients. Medical records of patients were also observed.
Results: It was found that 74% of the patients of chronic illness suffer from mild to severe degree of social dysfunction (where criteria for chronic illness=1 year or more). Among these, 47% had moderate level of social dysfunction, while 6% had severe degree of social dysfunction. Results also indicate that 35% of the patients had psychiatric illness (among which 20.3% had depression) while 65% had non-psychiatric chronic illness (among which 9.9% had Ischemic Heart Disease). 23% comorbidity was present**.** Most of the chronically ill patients were females (57%). 67% of the patients were on regular treatment for their chronic illness.
Conclusion: There exists a high level (74%) of social dysfunction among patients with chronic illness. Both psychiatric and non-psychiatric chronic illnesses lead to social dysfunction. The rate of social dysfunction was found higher among psychiatric illnesses as compared to non-psychiatric illnesses. The study also highlighted the issue that social functioning of the patients is generally ignored when treatment plans are formulated; which is the major factor behind high rate of social dysfunction in chronic illness. Other factors; age, employment status, gender and education, are also associated with social dysfunction. Counselling services need to be developed in hospitals in order to improve the level of social functioning of patients with chronic illnesses.
Keywords: Social Dysfunction , Chronic Illness, Psychiatric illness, Ischemic heart disease, depression.

Correspondence: Dr. Hamid Rashid Khawaja
Assistant Prof Behavioral Sciences, AIMS AJKMC, Muzaffarabad
Email: drhamidrashid@yahoo.co.uk

Introduction

Health is defined by WHO[1,2] as "a complete state of physical, social, mental and spiritual well-being and not merely the absence of disease".

This definition expands the scope of health to not only physical or medical aspects, but also to social functioning of an individual, which is the way in which a person usually interacts in a society or social group.[3]

The social function can be described in terms of social interaction, performance, self-concept or emotional function of an individual.[4] According to the definition of health by WHO[1,2], any disturbance in physical, social, emotional or spiritual functioning/well-being can be described as ill-health, thus indicating a physical as well as social dysfunction in the individual. Social dysfunction can also be characterized in terms of behavior which affects the normal functioning of individuals thereby reducing their self-care and inducing distress and confusion in their lives.[5]

Social dysfunction occurs as a consequence of many different factors, the most prominent of which are chronic illnesses; a prolonged and progressing form of illness; as described by WHO.[6] Major chronic diseases which tend to be related to social dysfunction are stroke, cancer, diabetes, respiratory diseases and heart diseases. They account for almost 63% of the leading cause of death.[6, 7]

The severity of impact of chronic illnesses in a person's life can be observed in the form of social dysfunction. Studies have revealed that different chronic illnesses have been related to social life of patients, leading to social dysfunction.[8-11] Different diseases have different criteria for being diagnosed as chronic, ranging from a few months duration to many years of progress of disease. There are some diseases which prevail throughout the life of individual like diabetes, blood pressure, physical disabilities, some psychiatric disorders etc. Such chronic diseases with life-long prevalence leave a deep impact on social life of patients. Chronic illness becomes a part of patient's life, so unless one learns to adapt to it, one cannot function in a healthy way; a social dysfunction.

Among the various explanations of social dysfunction, one explained by Linn is this that social dysfunction occurs is a negative aspect of person's social adjustment[4]. This social adjustment could be in a person's self-system (including his/her self-concept, inner motivation, meaning of life and health concerns), interpersonal system (including emotional relations or problems) and a performance system (which includes peer relations, satisfaction from work, and participation in other social activities), any disturbance among which could correspond to social dysfunction.

It was found from a study[11] that chronic illness also affects the social functioning in children. They tend to become more submissive and isolated from social surroundings. It was also found [12] that children who suffer from chronic illness may have psychosocial and adjustment problems, thus leading to social dysfunction.

Chronic illnesses could be psychiatric and/or non-psychiatric. Co-morbidity can also be present. The level of severity of illness corresponds to the level of social dysfunction.

Psychiatric illnesses are major contributing factor towards social dysfunction. One major psychiatric chronic illness which leads to a very severe form of social dysfunction is schizophrenia[8]; in which there is a severe social skill deficit which significantly limits the patients' normal social interaction and work.

According to a study[13, 14], the social interaction and self-belief system of patients suffering from chronic illness also gets disturbed. They become socially isolated, their social activities get limited and most importantly because of their deteriorating health, they believe themselves to be a burden upon others (decreased self-worth). It was also found[11, 13] that social dysfunction hinders the proper social development of adolescents with

chronic illness (or physical disability). It was found that adolescents, who had physical disability or chronic illness, lacked in their self-maturation and peer relations. They remained isolated from social activities; thus showing social dysfunction.

Among the psychiatric disorders, depressive disorders and bipolar disorder also lead to social dysfunction. It was found[15] that patients with bipolar disorder scored low in the fields of social confidence, openness and conversational skills, thereby showing social dysfunction. In one study[16], it was found that with increasing severity of psychiatric illness (depression and anxiety), the level of social dysfunction also increased. Patients with depression had higher level of social dysfunction than patients of anxiety. It was also found that with the change and severity of depression or anxiety, the level of social disability also changed (increased or decreased, respective to the severity).

Among non-psychiatric illnesses, diabetes, cancer and stroke are the common source of social dysfunction. It was found from a study[17] that females who were suffering from breast cancer showed high levels of social dysfunction which included psychological distress and disturbed sexual and social functioning. Studies [18, 19] have also found that patients of diabetes have also scored low in their social functioning and quality of life. Their level of social dysfunction was also related to their demographic factors like socio-economic status, education, age etc. comorbidity has also played an important role in the social functioning of patients.

Developmental disorders also correspond highly towards social dysfunction. It was found that[13,20] developmental disorders like learning disabilities, ADHD, mental retardation and physical disabilities hinder the social development and function of individuals. Social isolation and disturbed peer relations are common problems of such patients.

The previous researches and the need for further exploration have led to the development of this study. This study aims to observe the relation between chronic illnesses (psychiatric and non-psychiatric) and social dysfunction, and other factors associated with them. The criteria for chronic illness in this study have been set to be at least 1 year of clinically diagnosed illness. This study is the first of its kind to be conducted in any district/ locale of Azad Kashmir, which adds highly into its significance.

Methodology

The study has been carried out using a quantitative research design.

Data has been collected using a standard questionnaire **"Social Dysfunction Rating Scale"** developed by Linn M in 1969. It is a 21-item scale which measures the negative aspects of an individual's social adjustment[4]. Three major categories have been made in this scale; the self-perception, interpersonal relations and social performance. The test takes about 30 minutes to administer and is administered in a semi-structured way by the examiner.

A total number of 300 participants have been selected using purposive sampling technique from medical and psychiatric OPDs of "Abbas Institute of Medical Sciences" (AIMS): a government hospital in the locality of Muzaffarabad. The study has been carried out over the duration of one and a half month; from Feb 1 2013 to March 15 2013.

Inclusion/ Exclusion criteria: Participants have been included in the study on the basis of following criteria:

- Only the patients who have been clinically diagnosed for a psychiatric or non-psychiatric chronic illness (illness lasting for 1 year or more after diagnosis) have been selected.

Table 1. Level of severity of social dysfunction (n=300)		
Social Dysfunction Severity	**Percentage**	
Very mild/ Negligible	26%	
Mild	21%	
Moderate	47%	74%
Severe	6%	
Psychiatric Chronic Illness	35%	
Non-psychiatric Chronic Illness	65%	
Comorbidity	23%	

- Patients have been selected only from AIMS hospital. Participants who experienced any physical, social, emotional or psychological trauma/accident in the last 6 months were excluded.

Ethics: The ethical approval for conducting this research was taken from The Executive Director, Abbas Institute of Medical Sciences Muzaffarabad. The ethics involved the protection of patient's privacy (social, medical and demographical) i.e. the social, demographical and medical data of the patients was to be used specifically under this research study only after the approved consent from the patients themselves. The patients/and their caretakers were briefed about the study beforehand and also had the right to stop participating in the study at any point. The informed consent of the patients was taken in a written form.

Procedure: The participants were selected after taking an informed consent (on a written consent form) and the purpose of the study was briefly explained. After the informed consent, the basic demographics of participants were collected. Data was also collected from the medical reports of the patients (regarding the severity and duration of their chronic illness). After that, "social dysfunction rating scale" was verbally administered to each of the participants and the results were recorded.

The recorded data was subjected to further analysis.

Results

The results indicate that about 74% of the patients of chronic illness suffer from mild to severe degree of social dysfunction. 26% of the patients had very low/neglectful degree of social dysfunction (where n=300 and criteria for chronic illness=1 year or more). (Table 1)

The results indicate that (with n=300) about 74% of the chronically ill patients suffer from mild-severe degree of social dysfunction; among which, majority (47%) have moderate level of social dysfunction. Severe degree of social dysfunction was present in about 6% of patients, while mild levels were indicated in 21% of the patients.

It also shows that 35% of patients had psychiatric illness while 65% had non-psychiatric chronic illness. 23% comorbidity was present.

The results show that majority of the chronically ill patients who indicated levels of social dysfunction were suffering from Depression (20.3%), Anxiety (14.4%), Hypertension/IHD (9.9%) and epilepsy (9.5%). (Table 2)

The psychiatric illnesses with comorbid condition were Depression and Anxiety.

Table 2. Social dysfunction in psychiatric & non-psychiatric illnesses (n=222)	
Illness	**Social Dysfunction**
Psychiatric	
Depression	20.3%
Anxiety	14.4%
Psychotic Illness	10.8%
Non-Psychiatric	
Diabetes	8.5%
Paraplegia	1.3%
CVA	9%
Hypertension/IHD	9.9%
COPD	7.2%
Arthritis	9%
Epilepsy	**9.5%**

This result indicates that majority of the patients identified with social dysfunction (73%) were suffering from illness between duration 1 to 5 years

Table 3. Duration of chronic illness & treatment history (n=222)	
Patients On treatment	**Percentage**
Regular treatment	67%
Irregular treatment	33%
Duration of chronic illness	
1-5 years	73%
6-10 years	23%
11-15 years	3%
More than 15 years	1%

while the no. of patients seeking regular treatment was 67%. (Table 3)

This result indicates that majority of the patients with chronic illness (47%) were between 41-60 yrs. of age. Most of the chronically ill patients were females (57%) and only 13% were educated above matric level. (Table 4)

Table 4. Demographic data (n=300)	
Demographic variable	**Percentage**
Age	
>20 yrs	11%
21-40yrs	23%
41-60yrs	47%
61-80+ yrs	19%
Gender	
Males	43%
Females	57%
Education	
Illiterate	2%
Primary	15%
Middle	37%
Matric	33%
Above matric	13%

This result indicates that unemployment rated high among female patients (34.7%) while majority of male patients were employed (31.1%).

(Table 5)

Table 5. Employment Status (n=300)		
	Employed (%)	**Unemployed (%)**
Male	31.1%	11.4%
Female	22.8%	34.7%
Total	54%	46%

Discussion

The results of the study have indicated that a large number of chronically ill patients (74%) have been suffering from mild-severe levels of social dysfunction (47% having moderate levels of social dysfunction) (table1). These results have been consistent with the previous studies which indicate that chronic illness always impacts social functioning of patients.[8-11] Among the chronically ill, 35% had been suffering from psychiatric illness; while 65% were having non-psychiatric chronic illness. But, it was found that social dysfunction rated higher among patients of psychiatric chronic illness (table 2) with Depression and Anxiety having the highest levels of social dysfunction (20.3% and 14.4% respectively). This explains the fact that psychiatric disorders are a major source of producing social dysfunction.[8,13-16] These findings highlight the influence of psychiatric disorders on social life of patients: the self-esteem, social relations and social performance are greatly affected by the severity of psychiatric illnesses. However, it does not lessen the impact of non-psychiatric chronic illnesses. It was found that level of social dysfunction was affected by the severity of both psychiatric as well as non-psychiatric illness (table 1). Although the most severe form of social dysfunction in non-psychiatric illnesses was present among patients of paraplegia, but, social dysfunction rated higher in IHD (Ischemic Heart Disease), CVA and Epilepsy. This finding highlights another important fact that, generally people consider diseases like CVA and IHD as "common" because of their high prevalence, and in doing so, they ignore the high influence of such diseases upon the psychosocial functioning of the individual.

Comparative analysis of social dysfunction among psychiatric and non-psychiatric illnesses

pours light on a significant issue that despite the high rate of social dysfunction among patients with psychiatric illness, people tend to have ignorant attitude towards the severity of implications of such diseases. The major reason observed behind this difference was this that patients of non-psychiatric illness (especially cardiovascular patients and diabetics) learned to adapt to their illness and accepted it as a part of their life. The social system also comprehends such illnesses easily. But on the other hand, people with psychiatric problems face much more social problems than non-psychiatric patients because both the patient and the society do not understand this illness properly. They have difficulty in adapting to their illness and so it increases their social dysfunction.[21, 22]

It was also observed that, with the severe nature of chronic illness, chances of developing comorbid psychiatric disorder also increased. 23% comorbidity was found in the chronically ill patients. The common psychiatric illnesses found comorbid with non-psychiatric illness were depression and anxiety, which further explains the higher levels of social dysfunction.

An important fact found from the study was the ignorant attitude of people towards treatment.[23] Among the 74% chronically ill patients, 33% were not on regular treatment (table 3). The irregularity in treatment process is the major reason behind increasing duration of illness and higher levels of social dysfunction. An increasing trend was observed in the duration of illness. Majority of patients (73%) were suffering from chronic illness for duration between 1-5 years. It explains that if left untreated, the illness could get prolonged and more disturbing for social life.

The demographics were also related to the social dysfunction and chronic illnesses (table 4), as found consistent with previous findings.[18, 19] About 47% of the chronically ill were between age 41-60 (adults). This is a very critical issue regarding general health of population. Adulthood is the period of strength and maturity at which time individuals are deeply interconnected in the social circle of family and other social relations (work, friends etc.), but if it gets burdened because of chronic illnesses, it can produce damaging effects on both the individual and his/her immediate relations.[13] Subsequently, the social dysfunction also increases. It was also found that females faced more social dysfunction than males. This can also be explained through the findings that most of the patients were unemployed; specifically females (table 5). The social dysfunction levels increase in patients as the economic stress increases. Chronic illness reduces the physical and mental strengths of an individual thereby weakening his/her socio-economic/ employment position, and if the individual is unemployed, it leads to more complications in social functioning of the person.

The study also highlighted the low literacy rate among patients. Most of them (54%) were educated below matric level (table 4). The lack of education explains the ignorant attitude towards treatment. If one is not fully aware about the issues of health, then one cannot take full care of his/her health.[21,22] Hence, the employment status, lack of education and gender differences contribute in the ignorant attitude towards health care. Unhealthy habits lead to chronic illnesses and then towards social dysfunction.

This study has yielded results consistent with the previous studies. Increased severity of chronic illness leads to higher levels of social dysfunction, which is also related to socio-demographic factors.[16, 18, 19]

Conclusion

There exists a high level of social dysfunction among patients with chronic illness. Both psychiatric and non-psychiatric chronic illnesses lead to

social dysfunction. The rate of social dysfunction was found higher among psychiatric illnesses as compared to non-psychiatric illnesses. The study also highlighted the issue that social functioning of the patients is generally ignored when treatment plans are formulated; which is the major factor behind high rate of social dysfunction in chronic illness. Other factors; age, employment status, gender and education, are also associated with social dysfunction. Counseling services need to be developed in hospitals in order to improve the level of social functioning of patients with chronic illnesses.

LIMITATIONS: One major limitation of the study was the lack of previous researches on the topic in the locale of Muzaffarabad. There was also the limitation of trained personnel to conduct the study due to which the study was limited to a small sample size and only two departments of the hospital.

RECOMMENDATIONS: On the basis of study findings, it has been recommended that chronically ill patients and their families be provided basic guidance and counseling to reduce their level of social dysfunction. Simple vocational training and rehabilitation facility need to be established for patients with severe social dysfunction.

References

1. Bonita R, Beaglehole R, Kjellstrom T. *Basic Epidemiology.* 2nd ed. [Online] Switzerland: WHO Press; 2006. Available from http://whqlibdoc.who.int/publications/2006/9241547073_eng.pdf
2. World Health Organization. *WHO Definition of Health.* [Online] Available from http://www.who.int/about/definition/en/print.html
3. Kim J.S. *Sense of Mastery, Physical and Social Functioning, and Health-related Quality of Life in Patients with Defibrillators.* [Online] Indiana: ProQuest Publisher; 2007. Available from http://books.google.com.pk/books?id=jy6b6AZHOWQC&printsec=frontcover
4. IN-CAM Outcomes Database. *Social Dysfunction Rating Scale.* [Online] Available from http://www.outcomesdatabase.org/node/723.
5. Trull TJ. *Clinical Psychology.* 7th ed. [Online] USA: Thomson Wadsworth; 2005. World Health Organization. *Chronic diseases*.
6. Yach D, Hawkes C, Gould L, Hofman KJ. The global burden of chronic diseases: Overcoming impediments to prevention and control. *JAMA*. [Online] 2004; 291(21): 2616-2622.
7. De Silva MJ, Cooper S, Li HL, Lund C, Patel V. "Effect of psychosocial interventions on social functioning in depression and schizophrenia: meta-analysis." *The British Journal of Psychiatry*. [Online] 2013; 202(4): 253-260.
8. Pinquart M. Academic, physical and social functioning of children and adolescents with chronic physical illness. *J PediatrPsychol.* [Online] 2012; 37(4): 376-389.
9. Pinquart M, Shen Y. Behavioral problems in children and adolescents with chronic illness: a meta-analysis. *J Pediatr Psychol. [Online] 2011; 36(9): 1003-1016.*
10. Pinquart M, Teubert D. Academic, physical and social functioning of children and adolescents with chronic physical illness: a meta-analysis. *J Pediatr Psychol. [Online] 2012; 37(4): 376-389.*
11. Suris JC, Michaud PA, Viner R. The adolescent with a chronic condition, Part I: Developmental Issues. *Arch Dis Child. [Online] 2004; 89: 938-942.*
12. Falvo D. *Medical and Psychosocial Aspects of Chronic Illness and Disability.* 5th ed. [Online] Burlington: Jones & Bartlett Publishers; 2013. Available from http://books.google.com.pk/books?id=SdM6FsykfWAC&printsec=frontcover
13. Kramer-Kile M, Osuji JC, editors. *Chronic Illness in Canada: Impact and Intervention.* [Online] Burlington: Jones & Bartlett Publishers; 2012.
14. Rocca de ACC, Soares de MMB, Gorenstein C, Tamada RS, Issler CK, Dias RS, Schwartzmann AM, Lafer B. Social dysfunction in bipolar disorder: pilot study. *Aust N Z J Psychiatry.* [Online] 2008; 42(8): 686-692.

15. Rubin KH, Asendorpf JB, editors. *Social Withdrawal, Inhibition, and Shyness in Childhood*. [Online] New York: Psychology Press; 2014.
16. Bloom J R, Stewart S L, Oakley-Girvan I, Banks P J, Shema S. Quality of life of younger breast cancer survivors: persistence of problems and sense of well-being. *Psycho-Oncology*. [Online] 2012; 21(6): 655–665. doi: 10.1002/pon.1965
17. Penckofer S, Quinn L, Byrn M, Ferrans C, Miller M, Strange P. Does glycemic variability impact mood and quality of life? *Diabetes Technology & Therapeutics*. [Online] 2012; 14(4): 303-310.
18. Marrett E, Radican L, Davies MJ, Zhang Q. Assessment of severity and frequency of self- reported hypoglycemia on quality of life in patients with type 2 diabetes treated with oral antihyperglycemic agents: A survey study. *BMC Res Notes*. [Online] 2011; 4(251).
19. Jawaid A, Riby D M, Owens J, White S W, Tarar T, Schulz P E. 'Too withdrawn' or 'too friendly': considering social vulnerability in two neurodevelopmental disorders. *Journal of Intellectual Disability Research*. [Online] 2012; 56: 335–350.
20. Jorm AF. Mental health literacy: Public knowledge and beliefs about mental disorders. *The British Journal of Psychiatry*. 2000; 177: 396-401. doi:10.1192/bjp.177.5.396
21. Trotman HD, Kirkpatrick B, Compton MT. Impaired insight in patients with newly diagnosed nonaffective psychotic disordres with and without deficit features. Schizophrenia Research. [Online] 2011; 6(1-3): 252-256.
22. Pescosolido BA, Martin JK. Stigma and sociological enterprise. In: Avison WR, McLeod JD, Pescosolido BA (eds.) *Mental Health, Social Mirror*. NY, USA: Springer Publishers; 2007. p.307-328.