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P113 -The impact of acceptance of illness on quality of life outcomes for haemodialysis patients.

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Introduction: How patients accept illness has been identified as important for helping patients manage conditions that cannot be improved through medication or therapies. For example, it was shown to be beneficial for patients with chronic pain (1,2). Evidence from a range of chronic conditions suggests that more positive acceptance of illness facilitates improvements in patients' quality of life (QoL) (3–5). For patients receiving haemodialysis, the treatment is essential for survival, yet how patients adapt to dialysis can influence both clinical and psychological outcomes. It is therefore important to assess the role of acceptance and related factors among haemodialysis patients so that acceptance-based interventions, specifically tailored for dialysis, can be developed. This study aimed to assess how acceptance influences QoL for haemodialysis patients.

Method: A total of 97 haemodialysis patients completed the Kidney disease quality of life questionnaire (KDQoL) which measures three components of quality of life; kidney disease component, physical component, and mental component. They also completed the acceptance of illness scale (AiS), the depression anxiety and stress scale (DASS) and the illness cognitions questionnaire (ICQ). Sample characteristics were consistent with the national profile in terms of age and gender. Most participants received haemodialysis in hospital with a minority receiving haemodialysis at home.

Results: Acceptance of illness scores were associated with age ($r=0.218$, $p=0.033$), employment $F(7,87)=2.42$, $p=0.026$) and income ($F(6,84)= 2.593$, $p=0.024$), and with other predictor variables including depression (-0.700, $p <0.01$), helplessness ($r=-0.753$, $p <0.01$) and stress ($r=-0.693$, $p <0.01$). The regression analyses indicated that demographic differences accounted for a small proportion of variance in kidney disease QoL component (18.6%), physical QoL component (7.9%) and mental QoL component scores (15%) but when depression and acceptance were included the variance accounted for rose for the kidney disease component (62.3 %), physical component (33.7%) and the mental component (53.3%). The regression model summary scores are presented in Table 1. The overall model for the kidney disease component was significant ($F (4,90) = 37.219$, $p < 0.01$) with a large effect. Acceptance was a significant independent predictor of kidney disease component and physical component, whereas depression was a significant independent predictor of kidney disease component and mental component. However, acceptance demonstrated an indirect effect on the mental component with the effect being mediated by depression ($Sobel = 0.547$, 95% CIs 0.3630 to 0.7762, $p < 0.0001$).

Discussion: The results suggest that although acceptance impacts especially on physical quality of life and the kidney disease-specific burden on quality of life, other factors also play a role. For haemodialysis patients, who must contend with this demanding treatment and the associated physical symptoms, increasing their acceptance of illness may reduce the dialysis-related burden they experience, thereby improving their quality of life. The indirect role of acceptance on mental QoL suggests that improvements in acceptance may affect depression and in turn lead to improvements in mental quality of life. Developing acceptance-based interventions specifically adapted for dialysis patients may be one avenue towards improving patients' quality of life and reduce the overall burden of treatment.