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CHARACTERISTICS OF SUBJECTIVE ATTITUDES TOWARDS DISEASES IN MODERN ADOLESCENTS OF DIFFERENT GENDER IDENTITY

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Abstract. This article examines how young people with different gender identities perceive disease and how their attitudes toward disease might be influenced by their gender roles. The study presents the results of a diagnostic analysis examining the relationship between gender identity and different ways of thinking about disease.

The study draws on the biopsychosocial model, emphasizing psychological factors in health assessment. It is found that current trends in social development view the concepts of "disease" and "health" not only as physiological states but also as psychological states. The research analyzes studies showing that individuals with different gender roles have completely different behavioral patterns, including health protection.

The experimental results obtained suggest that behavioral patterns are influenced by gender identity. When considering specific disease symptoms, it is essential to consider the individual's psychological characteristics, especially the effects of his or her subjective perception of social gender. This consideration is very important in formulating the therapeutic approach to various disease conditions.

Keywords: *health, disease, subjective attitude to disease, gender, gender identity*

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Recent global events have significantly changed views on maintaining global public health. The current situation is marked by the profound impact of the COVID-19 pandemic, which has fundamentally changed people's views. Even people who did not care about health in the past have reevaluated their point of view. Two years of tangible threats to health and life have inevitably led to realizing the importance of dealing constructively with disease, regardless of its causes. Therefore, Prevailing societal trends point to a continuing interest in preserving and maintaining health.

In discussing the importance of developing an effective attitudinal model for a disease, we must first address the term itself. The term "disease" refers to a disorder of structure or function in a human and is widely used in medicine.

In today's society, medicine has developed two predominant models for conceptualizing the development and progression of disease: the biomedical approach and the biopsychosocial approach.

The first model was first described in the seventeenth century and has since been considered the basic model for identifying the external factors of a disease. It consists of the following main components:

– the theory of cause

– the system of interconnection of the three objects "host," "pathogen," "environment"

– the origin of the disease at the cellular level

– the mechanistic theory.

The biomedical model assumes that the human body is a mechanism. In this case, the disease is the failure of a part of this mechanism [1].

As one can see, this model does not consider the social aspects and the psychological or behavioral factors that contribute to the onset and progression of a disease. In this model, deterioration of health is primarily attributed to physical factors, regardless of the underlying cause. Consequently, managing the disease and its treatment depends primarily on the expertise of healthcare providers rather than involving the patient. This approach does not always lead to favorable outcomes. Despite its limitations, this model has been used over a long period and is still used today.

The second disease model, the biopsychosocial model, emerged in the late 1970s. This model is based on a theory that views each disease as part of a comprehensive system that extends from the smallest particles to the entire biosphere. Within this system, all components are intimately connected. Significantly, each element is influenced by personal factors, considering the individual's experiences and behaviors. In this model, the progression of a disease is influenced not only by the skills of the medical staff but also by the personal characteristics of the patient and the resilience of his or her body. It emphasizes that recovery outcomes are shaped by medical expertise, patient characteristics, and the body's ability to resist the disease.

The biopsychosocial model primarily considers psychological factors in describing a person's health status. It should be emphasized that current social trends underscore the importance of redefining "disease" and "health." Instead of focusing exclusively on biological and physiological aspects, these terms should be understood primarily as a person's psychological state. This view is supported by various researchers, including A.N. Kharkovsky, who claims that disease not only disrupts physiological mechanisms but also involves spiritual dimensions [2]. In his analysis, Kharkovsky concludes that understanding the psychological nature of disease requires incorporating the concepts of personality and personal meaning. These insights have considerable validity and deserve agreement.

Indeed, to understand the nature of a particular disease and, more importantly, how individuals respond to the challenge of losing their health, it is necessary to consider all the building blocks of the human personality thoroughly. Although A.N. Kharkovsky rightly points out that "the question of

psychological understanding of disease is being discussed in the context of the pandemic, just as the question of disease is widely discussed today," it is worth noting that this idea is not entirely new. Our previous research [3] found that the issue of "disease and personality" is part of an entirely new perspective. This concept deals with the general causes of diseases and the causal interaction between personality and disease. In this case, diseases can cause personality changes, and personality can also cause changes in a pathological state.

These mutual influences are considered as two complementary constructs:

Personality → disease

Disease → personality

That is, personality affects the onset and progression of disease, but at the same time, a disease affects personality.

We can identify two main pathogenetic causal chains by examining how personality affects disease (personality → disease).

One of these chains shows how certain personality traits shape the external circumstances of a person's daily life through behavioral patterns. These circumstances, in turn, influence various aspects of the body's internal functions differently. Through physiological mechanisms, these factors ultimately contribute to the development and progression of a physical condition.

One of the most important ways personality influences disease is through the influence of individual characteristics on the spectrum of prevailing psychophysiological states, particularly emotional states, over time. These emotional states can alter the physiological balance in the body. As a result, this disruption of physiological homeostasis creates a context in which disease development occurs and influences disease progression. In certain diseases, personality not only influences the course of the disease but also plays a role in the development of the disease.

At the same time, within the framework of this concept, it should be noted that the influence of personality on the disease through psychological, psychophysiological, and physiological mechanisms can be both negative, aggravating the severity of the disease and causing its progression and positive, mitigating the severity of the course of the disease and contributing to its regression and elimination.

In analyzing the second construct (disease → personality), two main chains of cause-effect relationships can also be identified.

One shows how the altered internal environment of the body caused by the disease affects the functioning of the central nervous system, especially the brain, and these altered conditions lead to changes in mental processes and personality in general.

The second important way disease affects personality is through the psychological impact of disease as a significant life event. The experience of a disease is associated with significant personal meaning and shapes the psychological conditions of a person's life. This meaningful event is semiotic in nature and signifies a change in the overall psychological landscape. The

personal meaning of the disease changes other psychological meanings and reshapes the semiotic environment of a personality's existence and, thus, the personality itself. In this context, the interaction between "disease → personality" becomes a psychological theme closely related to the meaning of the disease in a person's life. Therefore, this particular aspect of the theme can be called psychodynamic, as it focuses on the dynamics of psychological meanings.

The effects of disease on personality are usually adverse and involve physiological and psychological mechanisms. However, the personality can counteract these harmful and often destructive effects by overcoming the disease's challenges. Such overcoming is possible by creatively reflecting on the disease in the larger context of one's life journey. When an existentially significant disease situation is creatively processed, the personality has the potential to become more mature and profound. This represents the positive influence of the disease on the personality.

The above arguments can be roughly illustrated as follows:

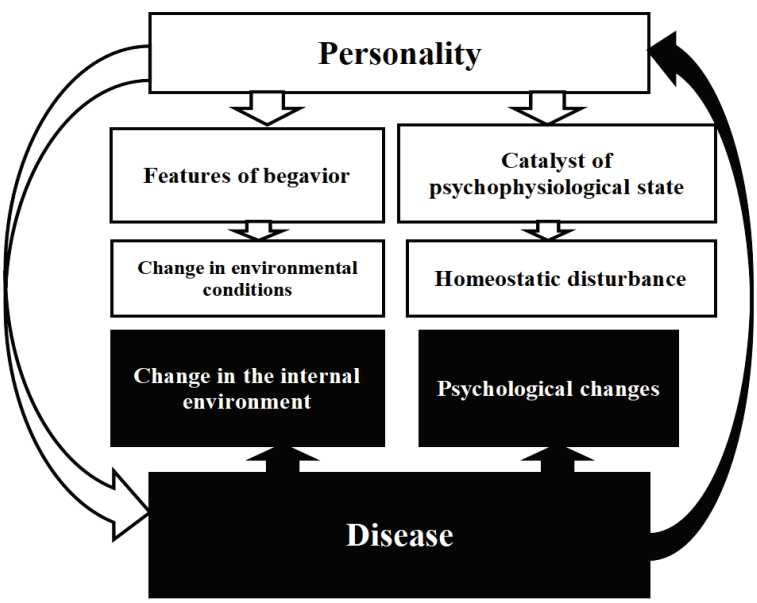

Fig. 1.

Thus, the double influence of the deterioration of health on a person's personality becomes clear; at the same time, personal characteristics indeed influence the course of disease. Reactions to a health diagnosis can vary widely: Some people downplay the significance of the disease, others recognize its severity and actively fight it, and others become depressed. Often, people adopt unconstructive behavior patterns, such as "actively suppressing thoughts of the disease" or "allowing the disease to dictate their lives." Each patient has a unique background and forms his or her own attitude toward health disorders. This reality fundamentally shapes the individual's approach to disease.

Based on our earlier analysis of research on the human response to disease, it is evident that various authors use a number of terms to describe the psychological phenomenon of responding to the loss of health. These terms include "autoplastic clinical picture" by A. Goldscheider, "internal clinical picture" by R.A. Luria, "experience of disease" by E.A. Shevalev and V.V. Kovalev, "feeling of disease" by E.K. Krasnushkin, "reaction to disease" by D.D. Fedotov, "adaptation reaction" by E.A. Shevalev and O.V. Kerbikov, "Position on disease" by Ya.P. Frumkin, Y.A. Mizrukhin, and N.V. Ivanov, "The Concept of disease" and "The Extent of disease" by V.N. Myasishchev, S.N. Myasishchev, S.S. Mizrukhin, N. Myasishchev, S.S. Libikh, and others [4–10].

While many authors addressing the topic of subjective responses to disease often associate these responses with specific diseases [11–14], recent studies have provided insights that illuminate a broader perspective. This shift in focus, prompted in particular by the recent wave of interest due to events such as the pandemic, suggests that attitudes toward health impairment and health in general, as well as readiness for treatment, are significantly influenced by a person's personal characteristics and past experiences. This conclusion is supported by the research of E.I. Rasskazova, A.Sh. Tkhostov, and V.A. Emelin [15, 16].

However, in discussions of the intertwining of "personality" and "disease," an important personality trait – "gender identity" – does not seem to be adequately considered. Typically, researchers analyzing diagnostic outcomes are limited to including respondents of different genders without acknowledging that sex does not always correspond to gender.

Our research follows a biopsychosocial model to understand how diseases progress and how people respond to certain symptoms. This means that we consider not only physical characteristics but also psychological factors. One important aspect we study is gender identity, which is how people identify themselves in terms of gender.

The study of gender is a multidisciplinary field that is approached from a variety of angles. In modern times, it is often associated with feminism and feminist theories. However, the concept of "gender" can be explored and understood by a variety of disciplines, including biology, sociology, psychology, anthropology, and political science. Biological theories, for example, focus on how the different biological roles of men and women contribute to gender differences. Sociological theories focus on the social structures that influence the development and functioning of gender roles. These theories primarily emphasize the construction of gender roles within institutions. On the other hand, psychological approaches focus on understanding gender roles at the individual level.

The concept of gender has a relatively short history compared to concepts such as class. Unlike class, which originated in nineteenth-century sociology, the idea of gender did not exist similarly. In the past, the term "gender" was used not only to describe the physical differences between men and women but also to define the social roles that each sex played. However, it later became

clear that "gender" was not comprehensive enough to encompass how people express themselves and behave in cultural and social contexts. In other words, terms like "masculine" and "feminine" were no longer sufficient regarding how cultural norms and traditions emerge and how certain behaviors are shaped. Researchers such as Mead and Rubin concluded as R.G. Petrova points out, that men and women have different roles that are not identical. Therefore, "gender" was needed to describe how society constructs expectations of men's and women's behavior and what meaning is given to each. It has also been noted that behavior patterns are often strongly dependent on gender [17].

The term "gender" was initially introduced by John Money in the 1940s as part of a discussion to validate sex reassignment. However, it was not used in the social sciences until the late 1960s. Since then, the concept of gender has taken a central role in conversations about various aspects of social life [17].

Thus, it can be said that gender identity represents a personal experience associated with one's gender. This shows the importance of considering gender identity when analyzing certain human behaviors. In general, people with different gender identities do not respond similarly to different life events. This is because society has socialized the two genders differently. Women with female gender identity are more emotional and have high emotional intelligence, which their personality traits can explain. Research also shows that girls tend to perform better than boys in empathy, social responsibility, and interpersonal relationships, reflecting their greater sensitivity to relationships with parents, friends, and siblings. These characteristics enable them to perceive and respond more sensitively to social and health-related changes [18].

Reaction to deterioration in health is inevitably associated with emotion. The expression of emotions varies between gender groups. This difference in the expression of emotional feelings is primarily shaped by gender stereotypes embedded in society. For example, when faced with circumstances that might elicit an angry response, people with masculine traits tend to react with anger. Conversely, in a similar situation, women are more inclined to express sadness and offense [19]. It is important to emphasize that there is little difference between the physiological responses of men and women.

Moreover, there are differences in how emotions are shown and their intensity between men and women. Several studies have shown that regardless of age, women are more expressive than men [20]. An interesting observation is that women tend to smile more often than men.

Despite widespread discussions about health maintenance, education, and gender identity issues, the study of how people of different genders respond to the loss of their health retains its importance and relevance.

The above analysis of studies reveals an obvious fact: individuals with different gender roles and individuals of different genders exhibit markedly different patterns of behavior even under identical circumstances. This divergence extends to behaviors related to health maintenance. A compelling example illustrates this phenomenon. According to the All-Russian Center for Public Opinion Research, "90% of men aged 30 to 40 answered in the affirmative to the question "Do you consider yourself healthy?" However, in

the same group, 45% said they smoke and 62% do little exercise. In contrast, when asked a similar question, women consider these factors and are aware of their harmful effects on health.

Some authors have studied this issue: I.B. Nazarova, T.V. Rogacheva, A.B. Diekman, A.N. Eagly, L.A. Hubbins, M. Szaflarski, S. Kreisler, H. Kreisler [21–25]

However, the recent pandemic and the increasing outbreaks of various diseases make it necessary to study how the total loss of health affects women and men.

In our opinion, it is important to consider the gender characteristics of men's and women's attitudes toward the disease and their psychological characteristics and not to disregard important details of their condition evaluation during the disease. Taking into account gender characteristics, gender identity of attitude to the disease can become an important factor in the overall improvement of the situation both in the field of health care and in the everyday life of carriers of different gender roles, the overall improvement of the level and quality of life of the population.

In our opinion, it is important to consider how men and women cope with diseases and their unique psychological characteristics and not to overlook the fact that the perception of their condition during the course of the disease has significant nuances. Taking into account gender specificities, gender identity of disease can become an important factor in the overall improvement of both health care and everyday life of people with different gender roles, leading to an overall improvement in the level and quality of life of the population.

To achieve this goal, the following methodological tools were used: "Masculinity-Femininity Methodology" (N.V. Dvoryanchikov), "Psychological Gender" (T.L. Bessonova), the Giessen Questionnaire on Somatic Complaints developed at the Psychosomatic Clinic of the University of Giessen (Germany) (adapted by the staff of the V.M. Bekhterev Psychoneurological Institute); the questionnaire "Type of attitude toward a disease" of the St. Petersburg V.M. Bekhterev Psychoneurological Research Institute; The results were statistically analyzed using the Wilcoxon T criterion. Quantitative and qualitative data were processed with the SPSS-21 software.

The empirical study was conducted at the I.A. Bunin Federal State Budgetary Educational Institution of Higher Education, "Eletsky State University named after I.A. Bunin." One hundred people participated in the study. The sample included young people of both sexes (i.e., young men and women) in equal proportions. The average age was 21 ± 4 years.

The main task of the first phase of experimental research was to determine the gender identity of the study participants.

The diagnostic data were analyzed without differentiation according to the gender of the respondents. This approach allowed us to evaluate the expressions of femininity, masculinity, and androgyny and to gauge each individual's subjective view of their own development of these characteristics.

The gender identity diagnosis yielded the following results:

Table 1

Degree of femininity, masculinity, and androgyny according to the "Masculinity-Femininity Methodology"

Types	Me-real	Me-ideal	Me-reflexive	Sexual preference type
Masculinity	60%	80%	40%	80%
Femininity	20%	20%	20%	20%
Androgyny	0	0	40%	0

The method of "Psychological Gender" allowed us to determine the quantitative correlation between masculinity and femininity.

Table 2

Relationship between masculinity and femininity according to the method of "Psychological Gender" (mean value and standard deviation)

Masculinity level	Femininity level
15.6 ± 3.2	9 ± 1.7

The results presented in Tables 1 and 2 show that the male type predominated among the subjects, regardless of the sex of the study participants.

Based on the results obtained, it was possible to divide the sample into two main groups, taking into account gender identity rather than sex: Respondents with pronounced masculinity and Respondents with pronounced femininity.

In order to collect initial data on the health status of the participants, a questionnaire on somatic complaints was completed. This step was crucial because the "type of attitude toward a disease" methodology presupposes an experience with a disease. With the help of the Giessen questionnaire on somatic complaints, we were able to identify young men and women without existing health problems. Regrettably, less than 1% of the participants fell into this category. The vast majority of students reported some form of health problem. This high prevalence underscores the importance of our study.

Table 3

The intensity of different types of physical disease according to the Giessen Somatic Complaints Questionnaire (mean and standard deviation)

Scales				
Exhaustion	Cardiac complaints	Stomach complaints	Various pains	The total intensity of complaints
5.47 ± 1.3	6.58 ± 2.5	5.26 ± 1.6	6.26 ± 1.4	20.25 ± 8.3

The methodology of the type of attitude to a disease that among the subjects participating in the study, five types of attitude to disease are diagnosed: ergopathic (stenic), anosognosic (euphoric), anxious (anxious-depressive and obsessive-phobic), hypochondriacal, neurasthenic.

We also examined the different attitudes toward disease in groups with masculine and feminine forms of gender identity, consistent with the aims of the study.

Table 4

Comparative characteristics of Type of Attitude to a Disease in groups with different forms of gender identity

Type of Attitude to a Disease	Subjects with feminine gender identity type	Subjects with masculine gender identity type
Anosognosic	4%	46%
Ergopathic	4%	33%
Hypochondriacal	27%	7%
Anxious	45%	6%
Neurasthenic	20%	8%

So we can conclude that most of the Feminine-type representatives have the following types of attitude to a disease: anxious, neurasthenic, and hypochondriacal.

Persons with the masculine gender identity relate to the disease mainly in accordance with the anosognosic and ergopathic types.

A comparison of attitude indicators towards a disease between persons with masculine and feminine gender identities revealed some notable differences.

Table 5

Significant differences between persons with masculine and feminine gender identity in the indicators of attitude toward a disease

Indicators	Mean values		*t*-criterion value	error probability	significance level
	Masculinity	Femininity			
Anosognosic	12.97	6.62	3.10	0.002	**
Ergopathic	21.64	17.64	3.27	0.001	**
Hypochondriacal	8.27	12.16	2.91	0.004	**
Anxious	10.49	14.59	3.52	0.0005	**
Neurasthenic	9.54	12.25	2.28	0.02	*

* Differences between the data of the masculine-type group and the data of the feminine-type group with a significance level $p \leq 0.05$.

** $p \leq 0.01$ (Wilcoxon rank sum test).

As shown in Table 5, the statistical analysis revealed significant differences in attitudes toward disease among individuals with different gender identities.

From the data collected, it can be concluded that respondents with a masculine gender identity tend to react to the presence of certain disease symptoms by downplaying their importance. They often avoid thinking about the existence of a disease or its possible consequences. Almost all symptoms are considered insignificant and not worthy of attention. Some dismiss these symptoms as mere “temporary fluctuations in well-being.” Typically, these people refuse medical examinations because they believe they can handle the problem themselves or hope it will resolve itself. They prioritize their work over health care and often refuse medical examinations. This tendency is often

attributed to work commitments or the need to continue working despite any challenges. These characteristics are consistent with the description of anosognosic and ergopathic attitudes toward disease according to the Type of Attitude to a Disease methodology.

Feminine subjects exhibit different behavioral patterns. They tend to be anxious and skeptical, often fearing complications due to the disease and ineffective treatments. They often tend to change physicians in hopes of finding a more successful treatment approach. These behaviors are often accompanied by feelings of melancholy and decreased mental engagement. The constant focus on painful sensations triggers a constant search for new symptoms. These traits correspond to the anxious and hypochondriacal behavior patterns described in the Type of Attitude to a Diseasy methodology.

As one can see from the above description of behavioral patterns, describing a person's psychological characteristics is essential in formulating treatment strategies for any type of disease. Recognizing behavioral responses and individual typological characteristics can help prevent the amplification of symptoms triggered by the stressful situation of the disease. Moreover, the results highlight that behavioral patterns and individual responses are often influenced by gender, which in contemporary contexts does not always coincide with biological sex.

The data collected may not be extensive enough to draw comprehensive conclusions. However, the results outlined again point to the urgent need to consider the psychological factors that influence the course of disease and the formulation of individual models of health-preserving behavior.

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ОСОБЕННОСТИ СУБЪЕКТИВНОГО ОТНОШЕНИЯ К БОЛЕЗНИ СОВРЕМЕННОЙ МОЛОДЕЖИ С РАЗЛИЧНОЙ ПОЛОРОЛЕВОЙ ИДЕНТИЧНОСТЬЮ

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Аннотация. Статья посвящена изучению особенности субъективного отношения к болезни представителей современной молодежи с различной полоролевой, гендерной идентичностью. Представлены результаты диагностического исследования взаимосвязи полоролевой идентичности и типов отношения к болезни.

В качестве методологической базы, рассматривается биопсихосоциальная модель, в рамках которой при характеристике состояния здоровья учитывает в первую очередь психологические факторы. Отмечается, что актуальные тенденции развития общества диктуют настоятельную необходимость рассмотрения таких понятий как «болезни» и «здоровья» в первую очередь не с физиологической точки зрения, но как некое психологическое состояние человека. Приводится анализ исследований, доказывающий, что носители разных гендерных ролей демонстрируют совершенно иные модели поведения в том числе и в сфере здоровьясбережения.

Полученные экспериментальные результаты позволяют заключить, что модель поведения обусловлены полоролевой идентичностью и в ситуации отражения тех или иных симптомов болезни учет психологических характеристик личности, в частности, влияние субъективного отражение своего социального пола, при построении лечебного процесса болезни любой нозологии просто необходим.

Ключевые слова: *здоровье, болезнь, субъективное отношение к болезни, гендер, полоролевая идентичность*

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