

Health Psychology: Psychological Adjustment to the Disease, Disability and Loss

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ABSTRACT

This article discusses the psychological adjustment of adults to severe or incurable diseases or other loss. The stress that results from a diagnosis of illness or loss depends on many factors, such as the beliefs of each individual and the social context. Considering the diversity of human perceptions, feelings and behaviors, it was considered important for the present study to include a theory of stress and treatment related to physical illness. At the center of attention are end-stage individuals, not their organic problems but mainly their psychological state and that of their families. Reference is then made to the loss of loved one and the period of mourning. As regards the disease response, there is a difference between the immediate reaction to loss, what we call mourning, and the adaptation to a new way of life without the loved one. Finally, the role of therapeutic communication between patients and their families and mental health professionals, as well as the need to maintain psychological balance, is also described.

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INTRODUCTION

The person affected by an incurable disease faces a series of threats, such as the threat of identity and future plans, the threat to social roles, his physical and psychological independence, his physical image, for relations, social stigma, isolation" (Lugton, 1999, pp 216). However, any person who develops a serious physical illness or experiences the loss of a loved one does not always show psychopathology as a consequence. To understand why, we need to take into account a model of the physiological process of stress adaptation (Mitchell, Chan, Bhatti, Halton, Grassi, Johansen & Meader, 2011). Psychopathology may then be thought to occur when the normal process of coping either does not work properly or works successfully only in part (Wethington, Glanz & Schwartz, 2015).

Disease as stress

The word "stress" is used in a number of ways. It sometimes refers to as an environmental stimulus - a threat or demand from the outside world (Schonfeld & Chang, 2017). According to this view, experiences are characterized by specific attributes (such as losses, challenges or dilemmas).

A second concept of stress applies to a physical condition, such that events are considered stressful and psychopestical only if they cause changes in the individual. The most well-

known example of the use of this concept comes from physiology. Stress in the normal sense is often used in everyday practice. When someone says he has intense stress, he usually means he is in a state of tension or excitation of the autonomic nervous system (McEwen, 2007).

A third way of understanding stress useful in the case of physical illness results from the interaction between the environmental requirements and the resources available to deal with them. This view finds structure in the Lazarus & Folkman transaction model. In fact, it is the most widely used theory (Lazarus & Folkman, 1991). It refers to the way the person understands and evaluates stressful stimuli.

According to this third theory, when individuals experience an unprecedented experience, they assess its potential impact and supplies (not clear). Stress arises when this estimate finds an imbalance between needs and supplies (Cohen, Kessler & Gordon, 1995).

Disease as a need or threat

Each human experience has certain features that increase the likelihood of it being considered threatening. These features include immediacy, ambiguity, control weakness or aversion. The

frequent interpretation of particular episodes in the same explains the resemblance of most human reactions to certain diseases. There is the possibility of a personalized interpretation leading to marked differences between people who seemingly have the same disorder. One's cognitive system guides their emotional and behavioral responses (Beck, 1995; McGinn & Young, 1996). Leventhal et al., have formulated a useful way to interpret a person's estimate of his illness:

- Identity
- reasoning
- consequences
- timetable
- curing or controlling the disease

More specifically, beliefs about a disease, such as how threatening it is, cannot be separated only on the basis of the characteristics of the disease itself as opposed to the social background. People may believe that the disease is inherited from a family member, that it is punishment for misconduct, or that they can be cured by strange methods (e.g. a specific diet). For some patients, the representation of the disease is directly related to self-representation. Thus, patients feel they live their illness and not "suffer" from it.

Disease manifests itself in a social and interpersonal context. While other people's reactions may be useful, they may also exacerbate the demands of the situation. For example, a partner may become depressed or withdraw, or family members can become sovereign and seek complete control. Illness a special situation, demanding the patient's role, but it may be at the cost of losing independence and certain rights (Losada, Montorio, Knight, Márquez & Izal, 2006).

During a secondary assessment, the ill person focuses on two elements: personal supplies and external supplies that can be obtained mainly from the direct social network. Personal skills can be defined in many ways, such as cognitive abilities, personal attributes or personality details.

Other equipment for the individual is social support. There are many approaches to understanding support that usually include four elements. The first type of emotional support creates the feeling that the person is receiving care. Second comes the reinforcement of self-confidence that promotes the feeling that the environment values and respects the individual. Third is practical help while fourth consists of information support that provides knowledge to help address the problem (Leventhal & Diefenbach, 1991; Leventhal & Nerenz, 1985; Leventhal, Nerenz & Steele, 1984; Weinman, Petrie, Moss - Morris & Horne, 1996).

Discussion about family reactions

Family reaction plays an important role in the support available. If the family rejects the condition and does not tolerate dependence (or fails to understand the patient's needs such as diet changes and more or less exercise), they can provide little

support. On the other hand they might become overprotective and refuse to allow some degree of autonomy on the part of the patient, thus discouraging an active participation in the treatment of the problem. Sometimes the members of a family have different opinions about the nature of a disease, causing internal conflicts. Most of the time, they share common views. If they are inaccurate, so-called family myths, it can be a difficult obstacle to accepting medical advice. (Doka, 2013; Elklit & Blum, 2011) This is often observed with chronic depression patients and caretakers who are also depressed; one reason is the tendency to have common dysfunctional beliefs and ways of dealing with problems.

According with the De Ridder, Geenen, Kuijter, & van Middendorp, (2008). To promote psychological adjustment, patients must remain as active as possible and allowed to express their emotions and take control of their lives, while engaging in self-management and trying to focus on the potential positive outcomes of their illness. Patients who use these strategies have the best chance of successfully adjusting to the challenges posed by a chronic illness. Additionally, according to Chibnall, Videen, Duckro & Miller (2002), attention must be given to the psychosocial spiritual dimension of the patient's life in order to buffer anxiety and depression.

The end-stage patient sees his or her life ending and experiences the oncoming death (Borg & Noble, 2010; Pennell & Corner, 2005). Adaptation to an end-stage disease has a lot in common with adaptation to other serious diseases and, therefore, it is not a specific field. This article discusses two issues: the diagnosis of depression and other adaptation disorders and the issue of suicide.

The person in an end-stage disease is expected to feel despair, while stress is a common symptom in such dying patients, but it is not necessarily pathological. As with depression, anxiety can be a result of physical disability and controlling the pain of pre-existing anxiety disorders (Corr, 1992; Leming & Dickinson, 2010). Akizuk, Shimizu, Asai, Nakano, Okusaka, Shimada & Uchitomi, 2015; Gouveia et al., 2015; Jadoon, Munir, Shahzad & Choudhry, 2010; Piquart & Duberstein, 2010; Traeger, Greer, Fernandez - Robles, Temel & Pirl, 2012). In these cases, a more detailed examination of the patient's behavior is necessary. (Gilbar, Or - Han & Plivazky, 2005). In addition, there may be no evidence of depression.

The findings of Chibnall, Videen, Duckro & Miller (2002) suggest that the experience of death distress among patients with life-threatening medical conditions is associated with the psychosocial spiritual dimension of the patient's life. Attention to these dimensions may buffer the negative effects of death distress.

Regarding the likelihood of end-stage suicide, the research findings belong to two categories: there are studies that conclude that the prevalence of suicidal

ideation in patients with end-stage cancer is less than 10% (Latha & Bhat, 2005; Lee et al., 2013; Park, Chung, & Lee, 2016). Such data contradict the clinical impression that patients express thoughts of assisted suicide, thus preserving the belief of a way out; and this can give them a sense of control of the situation (Borg & Noble, 2010; Breitbart, Rosenfeld, Pessin, Kaim, Funesti - Esch, Galiotta & Brescia, 2000).

In patients with a terminal stage Disease, suicide is an important complication in the first year after diagnosis, a time that carries a higher risk for suicide (Anguiano, Mayer, Piven, & Rosenstein, 2012). The two most important and treatable factors that need to be monitored by mental health professionals are uncontrollable pain and depression (Chochinov, 2001).

People expressing a desire to commit suicide are almost always ambivalent; even in patients with a terminal stage disease, the desire for death is not reasonable and should never be considered logical without searching for signs of latent external pressures and fear of symptoms in the termination phase. They might, however, have treatable depression.

The guiding principle of treating patients in the final stage of an illness is pain relief. Anxiolytic drugs can offer symptomatic relief from various conditions while the use of antidepressants in dying patients might be more problematic because of unwanted effects such as sleepiness and so on. Psychostimulant medications are also often used, which, for end-stage patients, can have beneficial stimulating properties such as increased energy, better concentration and increased appetite (Rosenstein, 2011).

Often, the terms "loss of laughter" and "mourning" are used identically. However, the Committee on the Effects of Loss on Health proposes the following clarification: loss is the deprivation of a loved one due to death (DSM- V) (Wheeler, Anstey, Lewis, Jeynes, & Way, 2014). Grief is the voluntary social expression of this deprivation while mourning is the inadvertently emotional and related behavioral reaction to it. Women seem to suffer from psychopathology as a consequence of experiencing loss more often. Men show less acceptance of loss and turn to other romantic relationships faster than women.

The duration of the mourning, according to Lindemann, is a function of the success of the individual's response to mourning. It entails breaking the bond with the dead, adjustment to a new environment and the creation of new relationships (Kostaridou-Heyklidis, 1999). Mourning is an individual process involving many symptoms. According to Lindemann (1944) the characteristics of normal mourning are as follows:

- physical symptoms
- for employment with the image of the deceased
- guilt

- hostility (irritability and anger)
- functional disruption

Other characteristics of the normal mourning reaction have since been recognized. Bowlby and others (in Buglass, 2010) group the symptoms in distinct phases:

- Phase 1 Shock and protest: including numbness and distrust as well as acute discomfort
- Phase 2 Excessive engagement including search
- Phase 3 Disorganization: when loss becomes reluctantly acceptable
- Phase 4 Solution: inappropriate stops to the deceased are rejected

Modern writers stress that this approach should not imply that the person who is mourning has to go through certain stages in the process. Perhaps less well-known are the positive aspects of the loss experience, such as the feeling of being able to make the most of the remaining time, increased independence and improved flexibility (Park, 2010; Zautra, 2009).

A key concern and challenge is the recognition of pathological mourning and other mental disorders caused by the loss of a loved one (Horowitz, Bonanno, & Holen, 1993). In this regard, abnormal sadness has several meanings. can be defined as:

- Chronic mourning or the failure to resolve all the unpleasant symptoms associated with the loss within six months.
- Injured Mourning, the absence of the expected symptoms of grief
- Late Grief, avoiding painful symptoms within the first two weeks of the loss

An unusually intense reaction to loss is sometimes described as pathological grief. There are indications that this form of grief may be a predisposing factor for psychiatric morbidity. An alternative way of defining pathological mourning is to examine whether it is accompanied by a major disruption of the person's functioning and, secondarily, to determine if it is unjustifiably resilient.

Depressive disorders are often caused by the loss of a loved one, but depressive symptoms are also part of the normal process of mourning. Symptoms are usually more frequent in the first four months and decrease rapidly over time. The DSM provides some guidance on the differential diagnosis of normal bereavement from depression. The following elements are rare in the loss of a loved one but are often found in major depression (Block & American College of Physicians-American Society of Internal Medicine End-of-Life Care Consensus Panel, 2005):

- guilt except at the time of death
- thoughts of death unrelated to the deceased
- depreciation
- psychomotor slowdown
- prolonged functional deterioration
- hallucinations irrelevant with him deceased

Another approach would be to think about the psychology of the person who has lost a loved one.

According to Beck (1995) and the cognitive model of psychotherapy, cognitive falsifications involving the world and the future, known as the Cognitive Trinity, are indicative of depression.

Although anxiety disorders have been studied less than depression, they can be observed after the loss of a loved one. It is necessary to consider the possibility of post-traumatic stress disorder after such loss, especially when death

Additional psychological complications due to the deprivation of a loved one include alcohol and substance abuse or even attempted suicide (Lawton, Gilbert & Turnbull, 2016). In social terms, complications of deprivation of a loved one include isolation and loss of social role, problems with work, loss of friends and financial difficulties. Medical complications are also common (Worden, 2018).

Variables involved in the development of psychopathology or medical co-morbidity as well as its intensity and duration for a child are low self-esteem, an amphi-thermic relation to the deceased, dependence on the dead and previous insecure relationships. In particular, an amphibious relationship between the survivor and the deceased is believed to predispose the sufferer to a pathological emotional response, based on the Freud's psychoanalytic approach. But there are equally important factors not related to the survivor such as unexpected death, prematurity, suicide or murder. Among other factors are poor social support and social isolation, low socio-economic situation and the stressful events that follow death (Mitchell, et al., 2011).

The treatment of emotional reactions after loss is controversial. There are experts who do not want to alter what they see as a normal process, even arguing that any treatment can negatively affect the process of mourning. However, the morbidity associated with complicated mourning may be subject to interventions. The traditional psychological treatment for suffering a loss involves treating mourning such that an expression of emotions is encouraged in conjunction with a review of what relationships mean. The techniques used for this purpose are psychoanalytic, cognitive-behavioral psychotherapy, cognitive analytical, and group and supportive psychotherapy, a brief-focused psychotherapy (Mitchell, et al., 2011).

Drug depression treatment due to loss seems to improve the symptoms within six weeks. The basic symptoms of mourning are not affected, but pharmacotherapy may be as effective as psychotherapy when a depressive disorder develops despite the apparent psychological significance of the effector (Mitchell, et al., 2011).

Communicating with health professionals
The patient finds help in his own way, through his own people, and sets his own limits. He usually finds strength through religious beliefs, those closest to him such as the people in his environment. The

patient can do it alone with a profound review of himself, but the focus is usually on the doctor and nursing staff responsible for alleviating pain. Therapeutic communication is one of the most important factors involved in the correct approach to the psychosocial side of the patient.

It is necessary for health professionals to treat the patient as the center of concern, in spite of prevailing unacceptable views of illness as offensive in the culture (Sheldon, 2009). The patient suffering from a serious illness is a major concern of the nursing staff, the physician and the health psychologist. Health professionals need to have the necessary training to cope with the gravity and leverage their therapeutic communication skills. The principles of palliative care include dialogue, understanding, courtesy and the acceptance of the patient's behavior, while also focusing on the patient's abilities and attitudes, particularly those that catalyze depression after diagnosis (Kozłowska & Doboszyńska, 2012; Sheldon, 2009).

Particularly in cases of patients suffering from life-threatening diseases, a particular kind of sensitive handling is needed as the idea of death can overwhelm the patient who is diagnosed with a life-threatening illness. Health professionals play a key role in making this life change less painful and helping patients prevail. Patients might prematurely assume future losses as well as unfinished plans (Khoshnazar, Rassouli, Akbari, Lotfi-Kashani, Momenzadeh, Rejeh & Mohseny, 2016).

Healthcare professionals and all those involved in the care of patients can provide holistic care only if they are able to recognize and cover the mental and emotional needs of their patients (Searle, 2001). Parkes (1998). To help those who are dying, they have to be prepared to stand by them and share their fears and try to diminish their panic. This includes a deep level of communication, which can be a privilege and also a painful experience. In short, care of people in the final stage is difficult and demanding. Health professionals are asked to support both the sick and the person's relatives. At the same time, however, they have to cope with their own feelings of pain, loss and death. Yet many consider (wrongly) that the influence and personal mourning of the health professional indicates a kind of weakness or failure. Thus, it is important that health professionals know their personal and professional limits. Appropriate training is necessary around illness and pain relief.

Conclusions

Overall, it is understood that the loss as experienced by the individual is not always the same, nor can it be studied with objective criteria. Loss is a subjective experience associated with each person's experiences, emotions, psychological condition, levels of physical pain, medication, and many other factors.

In any case, psychologists with specialization in health psychology are able to support the individual and his family by applying basic principles of therapeutic

communication and psychotherapy. Early intervention is significant in expected losses such as amputation of a member of the body or an imminent death, as well as continuous systematic and methodical scientific support and guidance for a better outcome.

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