B.Sc PSYCHOLOGY

5th SEM CORE COURSE

UNIVERSITY OF CALICUT

PSY5B05-HEALTH PSYCHOLOGY

2019 ADMISSION

Prepared by

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COURSE CODE	PSY5B05
TITLE OF THE COURSE	HEALTH PSYCHOLOGY
SEMESTER IN WHICH THE COURSE TO BE TAUGHT	**5th**
NO. OF CREDITS	**3**
NO. OF CONTACT HOURS	**48 (3hrs/week)**

Objectives of the course:

- To understand the Psychological, behavioural and cultural factors contributing to physical and mental health
- To study the management of different illnesses

- **Course details**

MODULE NO.	NAME OF MODULE	MODULE HOURS
1	**Introduction to health psychology**	**12**
2	**Health behaviour and primary prevention**	**12**
3	**Stress and coping**	**12**
4	**Psychosocial issues and management of advancing and terminal illness**	**12**

MODULE 1: Introduction to health psychology

HEALTH

WHO defined health as “a complete state of physical, mental and social well- being and not merely the absence of disease or infirmity.”

HEALTH PSYCHOLOGY

- Health psychology deals with the psychological and behavioral processes contributing to overall individual’s well -being and health.
- It deals with the subject of health and illness by merging all knowledge of biological, behavioral, social and psychological sciences.
- Health psychology is basically applying the psychological theory to health related practices.
- Health psychology can be defined as the aggregate of specific educational, scientific and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness and the identification of etiologic and diagnostic correlates of health, illness and related dysfunction.” (Matarazzo,1980)

The Mind-Body relationship

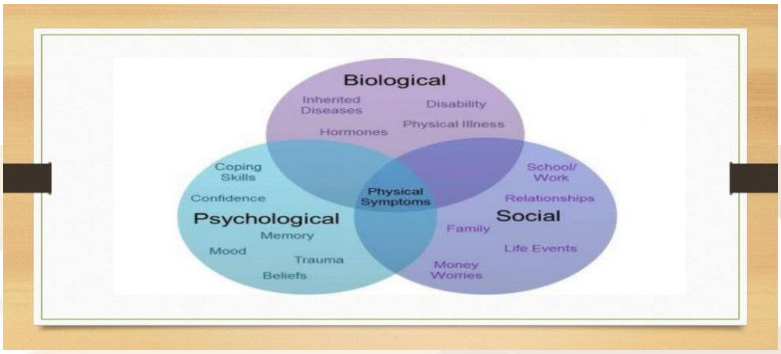
- **The Greeks:** They were among the first to identify the role of bodily functioning in health and illness. They developed humoral theory of illness, in which specific personalities were associated to four humors.
- **Middle ages:** Mysticism and demonology dominated the concepts of disease, which was “God’s punishment of evildoing". Throughout this time, the church was the guardian of medical knowledge.

- **Renaissance:** Great strides were made in the technological basis of medical practice, such as Leeuwenhoek's microscopy and Morgagni's contributions to autopsy.
- For the next 300 years, physical evidence became the sole basis for diagnosis and treatment of the illness.
- **Beginning of modern psychology:** Sigmund Freud's work on conversion hysteria.
- In 1930, unlike Freud's, Flanders Dunbar and Franz Alexander linked patterns of personality to a specific illness. Their works helped the emerging field of psychosomatic medicine.

NEED AND SIGNIFICANCE OF HP

- Changing patterns of illness
  - Acute illness
  - Chronic illness
- Advances in Technology and Research
- Role of epidemiology in Health Psychology
  - Morbidity – Numbers of cases of a disease
  - Mortality – Numbers of death
- Expanded Health Care Services
- Increased Medical Acceptance
- Demonstrated Contributions to Health
- Methodological Contributions to Health

BIOPSYCHOSOCIAL MODEL



- Interactions between individual genetic makeup (biology), mental health and personality (Psychology) and sociocultural environment (social world) contribute to their experience of health or illness.
- Theorized by Psychiatrist George L. Engel.
- **Biological Influences on Health:** It include genetics, infections, physical trauma, nutrition, hormones and toxins.
- **Psychological factors:** The psychological component looks for potential psychological explanations for a health problem, such as lack of self-control, emotional turmoil, or negative thinking.
- **Social factors:** Social and cultural factors are conceptualized as a particular set of stressful events that can differentially impact health depending on the individual and his or her social context.

BIOMEDICAL MODEL

- Focuses on the physical or biological aspects of disease and illness. It is a medical model of care practised by doctors and/or health professional and is associated with the diagnosis, cure and treatment of disease.
- Emphasis on diagnosis and treating individuals separately from their lifestyle/living conditions.

- Receives the majority of government healthcare funding.
- Played a large role in prolonging life expectancy.
- Eg: X-rays, Scans, Blood test, Ultrasound, Surgery

MODULE 2: health behaviour and primary prevention

HEALTH BEHAVIOURS

- Behaviors undertaken by people to enhance or maintain health.
- A health habit is a health behavior that is firmly established and often performed automatically, without awareness.
- These habits usually develop in childhood and begin to stabilize around age 11 or 12.

Changing Health Habits

❖ **Attitude change**

- **Educational appeals**: Educational appeals make the assumption that people will change their health habits if they have good information about their habits
- **Fear appeals**: This approach assumes that if people are afraid that a particular habit is hurting their health, they will change their behavior to reduce their fear.
- **Message framing**: A health message can be phrased in positive or negative terms. Messages that emphasize problems seem to work better for behaviors that have uncertain outcomes, for health behaviors that need to be practiced only once, such as vaccinations and for issues about which are fearful.

Cognitive Behavioural Approach

- Cognitive behavior approaches to health habit modification focus on the target behavior itself, the conditions to elicit and maintain it, and the factors that reinforce it. The most effective approach to health habit modification often comes from CBT.
- CBT interventions use several complimentary methods to intervene in the modification of a target problem and its context.

- CBT may be implemented individually, through therapy in a group setting,or even on the internet, and so it's a versatile as well as effective way of intervening to modify poor health habits.

➢ **Self- monitoring**

Self -monitoring assesses the frequency of a target behavior and the antecedents and the consequences of that behavior .The first step in self -monitoring is to learn to discriminate the target behavior. A second stage in self -monitoring is charting a behavior.Each of these condition can be a discriminative stimulus that is capable of eliciting the target behavior.

Stimulus control

- Once circumstances surrounding the target behavior are well understood, the factors in the environment that maintain poor health habits such as smoking, drinking and overeating can be modified.
- Stimulus control interventions involve ridding the environment of discriminative stimuli that evoke the problem behavior and creating new discriminative stimuli, signaling that a new response will be reinforced.

The self-control of behavior

- CBT focuses heavily on the beliefs that people hold about their health habits.
- The person acts as his or her own therapist and together with outside guidance learns to control the antecedents and consequences of the target behavior.
- Cognitive restructuring trains people to recognize and modify their internal monologues to promote health behavior change.

Self- reinforcement

Self- reinforcement involves systematically rewarding oneself to increase or decrease the occurrence of target behavior.

Behavioral assignments

A technique for increasing client involvement is behavioral assignments, home practice activities that supports the goals of a therapeutic interventions. Behavioral assignments are designed to provide continuity in the treatment of behavioral problem.

Social skills and relaxation training

Some poor health habits develop in response to the anxiety people experience in social situation. Many health habit modification programs like social skills training or assertiveness training are trained in methods that help people deal more effectively with social anxiety.

Relaxation training

Many poor health habits are caused or maintained by stressful circumstances and so managing stress is important to successful behavior change. A mainstay of stress reduction is RT involving deep breathing and progressive muscle relaxation

Motivational interviewing

MI is increasingly used in health promotion interventions.Originally developed to treat addiction.MI is a client centered counselling style designed to get people to work through any ambivalence they experience about changing their health behaviors. In MI, the interviewer adopts a known judgmental, non-confrontational, encouraging and supporting style.

Relapse prevention

One of the biggest problems faced in health habits modifications is the tendency for people to relapse. Following initial successful behavior change, people often return to their old bad

habits. **Abstinence violation effect** – a feeling of loss of control that results when a person has violated self- imposed rules. Relapse prevention should be integrated into treatment programs from the outset.

Health belief model

According to this model, whether a person practices a health behavior depends on two factors: whether the person perceives a personal health threat and whether the person believes that a participant health practice will be effective in reducing that threat.

Perceived health threat

The perception of a personal health threat is influenced by at least three factors: general health values, which include interest in and concern about health; specific beliefs about personal vulnerability to a particular disorder and beliefs about the consequences of the disorder such as whether they are serious.

Perceived threat reduction

Whether a person believes a health measure will reduce threat has two subcomponents: whether the person thinks the heath practice will be effective, and whether the cost of undertaking that measure exceeds its benefits.

Theory of planned behaviour

- According to this theory, a health behavior is the direct result of a behavioral intention.
- Behavioral intentions are themselves made up of 3 components:

1. Attitude toward the specific action
2. Subjective norms regarding the action

3. Perceived behavioral control

- Attitude toward the action center on the likely outcomes of the action and the evaluations of those outcomes.
- Subjective norms are what a person believes others think that person should do and the motivation to comply with those normative beliefs.
- Perceived behavioral control is the perception that one can perform the action and that action will have the intended effect; thus component of the model is similar to self- efficacy.
- These factors combine to produce behavioral intention and ultimately behavior change.

Trans theoretical model

J.O.Prochaska and his associates developed the trans theoretical model of behavior change, a model that analyzes the stages and processes people go through in bringing about a change in behavior and suggested treatment goals and interventions for each stage.

Precontemplation

- This stage occurs when a person has no intention of changing his or her behavior. Many people in this stage are not aware that they have a problem, although families, neighbors, or coworkers may well be.

Contemplation

- Contemplation is the stage in which people are aware that they have a problem and are thinking about it but have not yet made a commitment to take action.

Preparation

- In this stage, people intend to change their behavior but have not yet done so successfully. In some cases, they have modified the target behavior somewhat, such as smoking fewer

cigarettes than usual, but have not yet made the commitment to eliminate the behavior altogether.

Action

- The action stage occurs when people modify their behavior to overcome the problem. Action requires commitment of time and energy to making real behavior change. It includes stopping the behavior and modifying one's lifestyle and environment to rid one's life of cues associated with the behavior.

Maintenance

- In this stage, people work to prevent relapse and to consolidate the gains they have made.

Protection motivation theory

- The protection motivation theory deals with how people cope with and make decisions in times of harmful or stressful events in life. These decisions are a way of protecting oneself from perceived threats. The theory attempts to explain and predict what motivates people to change their behavior.
- The theory is used mainly as a model to explain decision making and action about health.
- PMT examines how people appraise their abilities to manage threats.
- The theory proposes the variable motivation to protection to explain health behaviors.
- Protection motivation theory was developed by **R.W. Rogers** in 1975 in order to better understand fear appeals and how people cope with them. However, Dr. Rogers would later expand on the theory in 1983 to a more general theory of persuasive communication.

Social cognitive theory

- Social cognitive theory is a learning theory developed by the renowned Stanford psychology professor Albert Bandura. The theory provides a framework for understanding how people actively shape and are shaped by their environment. In particular, the theory details the processes of observational learning and modeling, and the influence of self-efficacy on the production of behavior.
- The theory states that when people observe a model performing a behavior and the consequences of that behavior, they remember the sequence of events and use of this information to guide subsequent behaviors.
- Social cognitive theory considers many level of social ecological model in addressing behavior change of individuals.SCT has been widely used in health promotion given the emphasis on the individual and the environment ,the latter of which has been become a major of focus in recent years of health promotion activities.

Attribution theory

The origins of attribution theory lie in the work of Heider (1944, 1958), who argued that individuals are motivated to understand the causes of events as a means to make the world seem more predictable and controllable.

Attribution theory has been applied to the study of health and health behavior. The issue of controllability emphasized in attribution theory has been specifically applied to health in terms of the health locus of control. Individuals differ in their tendency to regard events as controllable by them (an internal locus of control) or uncontrollable by them (an external locus of control).

Models of prevention

Prevention strategy: types of prevention in general, preventive care refers to measures taken to prevent diseases instead of curing or treating the symptoms. The three levels of preventive care— primary, secondary, and tertiary care—are detailed below:

- Primary prevention—those preventive measures that prevent the onset of illness or injury before the disease process begins.
- Secondary prevention—those preventive measures that lead to early diagnosis and prompt treatment of a disease, illness or injury to prevent more severe problems developing. Here health educators such as health extension practitioners can help individuals acquire the skills of detecting diseases in their early stages.
- Tertiary prevention—those preventive measures aimed at rehabilitation following significant illness. At this level health services workers can work to retrain, re-educate and rehabilitate people who have already developed an impairment or disability.

MODULE 3: Stress and coping

STRESS

Stress is a negative emotional experience accompanied by predictable biochemical, physiological, cognitive and behavioral changes that are directed either toward altering the stressful event or accommodating to its effects.

STRESSOR

An event or situation that causes stress.

APPRAISAL OF STRESS

- Stress is the consequence of a person's appraisal processes:
- **Primary appraisal** occurs as a person is trying to understand what the event is and what it will mean. Events may be appraised for their harm, threat, or challenge. Harm is the assessment of the damage that has already been done, as for example being fired from a job.
- **Secondary appraisals** assess whether personal resources are sufficient to meet the demands of the environment. When a person's resources are more than adequate to deal with a difficult situation, he or she may feel little stress and experience a sense of challenge instead.
- Stress, then, is determined by person-environment fit .It results from the process of appraising events (as harmful, threatening, or challenging), of assessing potential resources, and of responding to the events. To see how stress researchers have arrived at this current understanding, we examine the origins of stress research.

Fight or Flight

The earliest contribution to stress research was Walter Cannon's (1932) description of the fight-or-flight response. Cannon proposed that when an organism perceives a threat, the body

is rapidly aroused and motivated via the sympathetic nervous system and the endocrine system. This concerted physiological response mobilizes the organism to attack the threat or to flee; hence, it is called the fight-or-flight response.

At one time, fight or flight literally referred to fighting or fleeing in response to stressful events such as attack by a predator. Now, more commonly, fight refers to aggressive responses to stress, such as getting angry or taking action, whereas flight is reflected in social withdrawal or withdrawal through substance use or distracting activities. On the one hand, the fight-or-flight response is adaptive because it enables the organism to respond quickly to threat. On the other hand, it can be harmful because stress disrupts emotional and physiological functioning, and when stress continues unabated, it lays the groundwork for health problems.

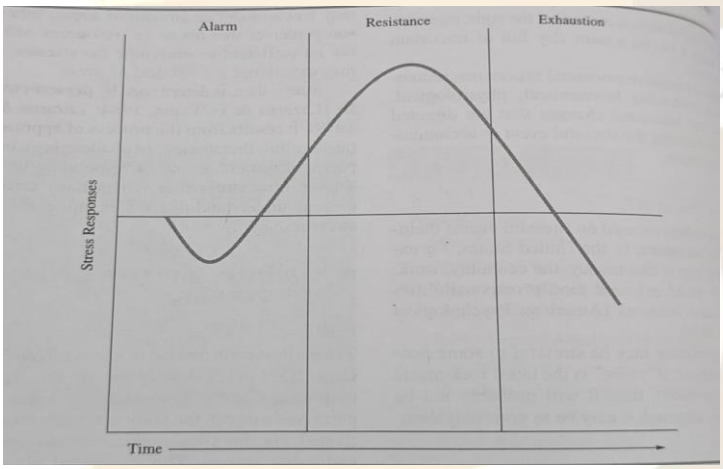
Selye's General Adaptation Syndrome

Another important early contribution to stress was Hans Selye's (1956, 1976) work on the general adaptation syndrome. Selye exposed rats to a variety of stressors, such as extreme cold and fatigue, and observed their physiological responses. To his surprise, all stressors, regardless of type, produced essentially the same pattern of physiological changes. They all led to an enlarged adrenal cortex, shrinking of the thymus and lymph glands, and ulceration of the stomach and duodenum.

From these observations, Selye (1956) developed the general adaptation syndrome. He argued that when a person confronts a stressor, it mobilizes itself for action. The response itself is nonspecific with respect to the stressor; that is, regardless of the cause of the threat, the person will respond with the same physiological pattern of reactions. Over time, with repeated or prolonged exposure to stress, there will be wear and tear on the system.

The general adaptation syndrome consists of three phases. In the first phase, alarm, the person be-comes mobilized to meet the threat. In the second phase, resistance, the person makes

efforts to cope with the threat, as through confrontation. The third phase, exhaustion, occurs if the person fails to overcome the threat and depletes physiological resources in the process of trying.



Tend-and-Befriend

In response to stress, people (and animals) do not merely fight, flee, and grow exhausted. They also affiliate with each other, whether it is the herding behavior of antelope in response to a predator or the coordinated responses to a stressor that a community shows when it is under the threat of a hurricane.

S. E. Taylor and colleagues developed a theory of responses to stress termed tend-and-befriend. The theory maintains that, in addition to fight or flight, people and animals respond to stress with social affiliation and nurturant behavior toward offspring. These responses to stress may be especially true of women.

During the time that responses to stress evolved, men and women faced somewhat different adaptive challenges. Whereas men were responsible for hunting and protection, women were responsible for foraging and child care. These activities were largely sex segregated, with the result that women's responses to stress would have evolved so as to protect not only the self but offspring as well. These responses are not distinctive to humans. The offspring of most

species are immature and would be unable to survive, were it not for the attention of adults. In most species, that attention is provided by the mother.

Tend-and-befriend has an underlying biological mechanism, in particular, the hormone oxytocin. Oxytocin is a stress hormone, rapidly released in response to some stressful events, and its effects are especially influenced by estrogen, suggesting a particularly important role in the responses of women to stress. Oxytocin acts as an impetus for affiliation in both animals and humans, and oxytocin increases affiliative behaviors of all kinds, especially mothering.

In addition, animals and humans with high levels of oxytocin are calmer and more relaxed, which may contribute to their social and nurturant behavior.

Research supports some key components of the theory. Women are indeed more likely than men to respond to stress by turning to others. Mothers' responses to offspring during times of stress also appear to be different from those of fathers in ways encompassed by the Tend-and-befriend theory. Nonetheless, men, too, show social responses to stress, and so elements of the theory apply to men as well.

Negative Events

- Negative events produce more stress than do positive events. Shopping for the holidays, coping with an unexpected job promotion, and getting married are all positive events that draw off time and energy. Nonetheless, these positive experiences are less stressful than negative or undesirable events, such as getting a traffic ticket, trying to find a job, coping with a death in the family, getting divorced or experiencing daily conflict. Rejection targeted at you specifically by an-other person or group is particularly toxic. Negative events produce more psychological distress and physical symptoms than positive ones do.

Uncontrollable Events

- Uncontrollable or unpredictable events are more stressful than controllable or predictable ones especially if they are also unexpected When people feel that they can predict, modify, or terminate an aversive event or feel they have access to someone who can influence it , they experience less stress, even if they actually can do nothing about it .Feelings of control not only mute the subjective experience of stress but also influence biochemical reactions to it , including catecholamine levels and immune responses.

Ambiguous Events

- Ambiguous events are more stressful than clear-cut events. When a potential stressor is ambiguous, a person cannot take action, but must instead devote energy to trying to understand the stressor, which can be a time-consuming, resource-sapping task. Clear-cut stressors, on the other hand, let the person get on with finding solutions and do not leave him or her stuck at the problem definition stage. The ability to take confrontative action is usually associated with less distress and better coping.

Overload

- Overloaded people experience more stress than people with fewer tasks to perform. For example, one of the main sources of work-related stress is job overload, the perception that one is responsible for doing too much in too short a time.

Personality and coping

The personality characteristics that each person brings to a stressful event influence how he or she will cope with that event.

Negativity, stress and illness

- Research has especially focused on negative affectivity: a pervasive negative mood marked by anxiety, depression and hostility.

- People high in negative affectivity (also called neuroticism) express distress, discomfort and dissatisfaction in many situations.
- Negative affectivity is related to poor health, including such chronic disorders as arthritis, diabetes, chronic pain and coronary artery disease.
- Negative affectivity is also related to all-cause mortality.
- Taken together this research suggests that psychological distress involving depression, anger, hostility and anxiety may form the core of a **disease prone personality.**
- Negative affectivity is related to elevated levels of stress indicators such as cortisol, heart rate, inflammation and risk factors for coronary heart disease.
- A second link is poor health.
- Negative affect leads people to worry, be more aware of their symptoms and attribute their symptoms to poor health.
- People who are high in negative affect are more likely to get sick, but they also are distressed, experience physical symptoms and seek medical attention even when they are not sick.

Positivity and illness

- Positive emotional functioning promotes better mental and physical health and a longer life.
- Positive emotional states have been tied to lower levels of stress indicators such as cortisol and better immune responses to challenges such as exposure to flu virus
- When people are feeling positive, they also invest time and effort to overcome obstacles in pursuit of their goals, which may accordingly affect their mood and lower their stress levels.
- In addition to promoting general well-being, positivity promotes several specific psychological resources that improve coping to which we next turn.

SOCIAL SUPPORT

- Defined as information from others that one is loved and cared for, esteemed and valued and part of a network of communication and mutual obligations.
- Social support can come from parents, a spouse or partner, other relatives, friends, social and community contacts (such as churches or clubs) or even a devoted pet.
- Social support helps people thrive.
- People with social support experience less stress when they confront a stressful experience, cope with it more successfully and even experience positive life events more positively.
- Social support can take any of several forms.
- **Tangible assistance:** Involves the provision of material support, such as services, financial assistance or goods. Eg; the gifts of food that arrive after a death in a family mean that the bereaved family members will not have to cook for themselves and visiting friends and family.
- Family and friends can provide **informational support** about stressful events. For example, if an individual is facing an uncomfortable medical procedure, a friend who went through the same thing could provide information about the exact steps involved, the potential discomfort experienced and how long it takes.
- Supportive friends and family can provide **emotional support** by reassuring the person that he or she is a valuable individual who is cared for. The warmth and nurturance provided by other people can enable a person under stress to approach the stressful event with greater assurance.
- Research suggests that when one receives help from another but is unaware of it , that help is most likely to benefit the recipient- **Invisible support**
- Social support can lower the likelihood of illness, speed recovery from illness or treatment and reduce risk of mortality due to serious disease.

- Social support also typically benefits health behaviors.

STRESS MANAGEMENT PROGRAM

- **Identifying Stressors:** In the first phase of the program, participants learn what stress is and how it creates physical wear and tear. In sharing their personal experiences of stress, many students find reassurance in the fact that other students have experiences similar to their own. They learn that stress is a process of psychological appraisal rather than a factor inherent in events themselves.
- **Identifying Stress Antecedents**

  Once students learn to chart their stress responses, they are taught to examine the antecedents of these experiences. They learn to focus on what happens just before they experience feelings of stress.
- **Avoiding Negative Self-Talk**

  Students are next trained to recognize and eliminate the negative self-talk they go through when they face stressful events.
- **Completing Take-Home Assignments**

  In addition to in-class exercises, students have taken home assignments. They keep a stress diary in which they record what events they find stressful and how they respond to them. As they become proficient in identifying stressful incidents, they are encouraged to record the negative self-statements or irrational thoughts that accompany the stressful experience.
- **Acquiring Skills**

  The next stage of stress management involves skill acquisition and practice. These skills include cognitive-behavioral management techniques, time management skills, and other stress-reducing interventions, such as exercise. Some of these techniques are designed to eliminate the stressful event; others are geared toward reducing the experience of stress without necessarily modifying the event itself.

- **Setting New Goals**

  Each student next sets several specific goals that he or she wants to meet to re-duce the experience of college stress. For one student, the goal may be learning to speak in class without suffering overwhelming anxiety. For another, it may be going to see a particular professor about a problem. Once the goals are set, specific behaviors to meet those goals are identified. In some cases, an appropriate response may be leaving the stressful event altogether.

- **Engaging in Positive Self-Talk and Self-Instruction**

  Once students have set realistic goals and identified some target behaviors for reaching their goals, they learn how to engage in self-instruction and positive self-talk. Self-instruction involves reminding oneself of the specific steps that are required to achieve the goal. Positive self-talk involves providing the self with encouragement.

- **Using Other Cognitive-Behavioral Techniques**

  In some stress management programs, contingency contracting and self-reinforcement are encouraged. Several other techniques are frequently used stress management interventions. Time management and planning helps people set specific goals, establish priorities, avoid time-wasters, and learn what to ignore. Most stress management programs emphasize practicing good health habits and exercise at least20-30 minutes at least 3 times a week. Assertiveness training is sometimes incorporated into stress management.

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MODULE 4: psychosocial issues and management of advancing and terminal illness

EMOTIONAL RESPONSES TO CHRONIC HEALTH DISORDERS

- Immediately after a chronic health disorder is diagnosed, a patient can be in a state of crisis marked by physical, social, and psychological disequilibrium.
- If the patient's usual coping efforts fail to resolve these problems, the result can be an exaggeration of symptoms and their meaning, indiscriminate efforts to cope, an increasingly negative attitude, and worsening health. The uncertainty and ambiguity inherent in many chronic disorders (e.g., Will it get worse? If so, how quickly?) affects quality-of-life adversely.
- People with chronic health disorders are more likely to suffer from depression, anxiety, and generalized distress.
- These psychological changes are important because they compromise quality of life, predict adherence to treatment, and increase the risk of dying early.

Denial

- Denial is a defense mechanism by which people avoid the implications of a disorder, especially one that maybe life-threatening. It is a common early reaction to chronic health disorders.
- Patients may act as if the health disorder is not severe, it will shortly go away, or it will have few long-term implications. Immediately after the diagnosis of the health disorder, denial can serve a protective function by keeping the patient from having to come to terms with problems posed by the health disorder when he or she is least able to do so.

- Over time, however, any benefit of denial gives way to its costs. It can interfere with taking in necessary treatment information and compromise health.

Anxiety

- Following the diagnosis of a chronic health disorder, anxiety is also common.
- Many patients are over-whelmed by the potential changes in their lives and, in some cases, by the prospect of dying.
- Anxiety is especially high when people are waiting for test results, receiving diagnoses, awaiting invasive medical procedures, and anticipating or experiencing adverse side effects of treatment.
- Anxiety is a problem not only because it is intrinsically distressing but also because it interferes with treatment.
- For example, anxious patients cope more poorly with surgery;
- Symptoms of anxiety may also be mistaken for symptoms of the underlying disease and thus interfere with assessments of the disease and its treatment

Depression

- Depression is a common reaction to chronic health disorders. Up to one-third of all medical inpatients with chronic disease report symptoms of depression, and up to one-quarter suffer from severe depression.
- Depression is especially common among stroke patients, cancer patients, and heart disease patients, as well as among people with more than one chronic disorder.
- At one time, depression was regarded only as an emotional disorder, but its medical significance is increasingly recognized.

- Depression predicts death from all causes.
- People who have intermittent bouts of depression are more likely to get heart disease, atherosclerosis, hypertension, stroke, dementia, and chronic disorders, most notably coronary heart diseases and Type II diabetes at younger ages.
- Depression exacerbates the course of several chronic disorders.
- Depression complicates treatment adherence and medical decision making.

STAGES TO ADJUSTMENT TO DYING

Kübler-Ross's Five-Stage Theory

- Elisabeth Kübler-Ross, a pioneer in the study of death and dying, suggested that people pass through five stages as they adjust to the prospect of death: denial, anger, bargaining, depression, and acceptance.
- Although research shows that people who are dying do not necessarily pass through each of these stages in the exact order, all of these reactions are commonly experienced.

1. Denial

- Denial is thought to be a person's initial re-action on learning of the diagnosis of terminal illness. Denial is a defense mechanism by which people avoid the implications of an illness.
- They may act as if the illness were not severe, it will shortly go away, and it will have few long-term implications.
- In extreme cases, the patient may even deny that he or she has the illness, despite having been given clear information about the diagnosis.
- Denial, then, is the subconscious blocking out of the full realization of the reality and implications of the disorder.

- Denial early on in adjustment to life-threatening illness is both normal and useful because it can protect the patient from the full realization of impending death.
- Usually it lasts only a few days. When it lasts longer, it may require psychological intervention.

2. Anger

- A second reaction to the prospect of dying is anger. The angry patient is asking, "Why me? Considering all the other people who could have gotten the illness, all the people who had the same symptoms but got a favorable diagnosis, and all the people who are older, dumber, more bad-tempered, less useful, or just plain evil, why should I be the one who is dying?“

3. Bargaining

- Bargaining is the third stage of Kübler-Ross's formulation. At this point, the patient abandons anger in favor of a different strategy: trading good behavior for good health.
- Bargaining may take the form of a pact with God, in which the patient agrees to engage in good works or at least to abandon selfish ways in exchange for better health or more time.

4. Depression

- Depression, the fourth stage in Kübler-Ross's model, may be viewed as coming to terms with lack of control.
- The patient acknowledges that little can now be done to stay the course of illness. This realization may be coincident with a worsening of symptoms, tangible evidence that the illness is not going to be cured. At this stage, patients may feel nauseated, breathless, and tired.

5. Acceptance

- The final stage in Kübler-Ross's theory is acceptance.
- At this point, the patient may be too weak to be angry and too accustomed to the idea of dying to be depressed.
- Instead, a tired, peaceful, though not necessarily pleasant calm may descend.

- Some patients use this time to make preparations, deciding how to divide up their remaining possessions and saying goodbye to old friends and family members.

THE MANAGEMENT OF TERMINAL ILLNESS IN CHILDREN

- Working with terminally ill children is perhaps the most stressful of all terminal care. As a result, family members, friends, and even medical staff may be reluctant to talk openly with a dying child about his or her situation.
- Nonetheless, terminally ill children often know more about their situation than they are given credit for. Children use cues from their treatments and from the people around them to infer what their condition must be. As their own physical condition deteriorates, they develop a conception of their own death and the realization that it may not be far off.
- It may be difficult to know what to tell a child. Unlike adults, children may not express their knowledge, edge, concerns, or questions directly. They may communicate the knowledge that they will die only indirectly, as by wanting to have Christmas early so that they will be around for it Or they may suddenly talking about their future plans.

- Counseling with a terminally ill child may be required and typically follows some of the same guidelines as is true with dying adults, but therapists can take cues about what to discuss from the child, talking only about those issues the child is ready to discuss.

  Parents, too, may need counseling to help them cope with the impending death. They may blame themselves for the child's illness or feel that there is more they could have done.

CONTINUED TREATMENT AND ADVANCING ILLNESS

- Advancing and terminal illness frequently bring the need for continued treatments with debilitating and unpleasant side effects.

- For example, radiation therapy and chemotherapy for cancer may produce dis-comfort, nausea and vomiting, chronic diarrhea, hair loss, skin discoloration, fatigue, and loss of energy. The patient with advancing diabetes may require amputation of extremities, such as fingers or toes.
- The patient with advancing cancer may require removal of an organ to which the illness has now spread, such as a lung or part of the liver.
- The patient with degenerative kidney disease may be given a transplant, in the hope that it will forestall further deterioration.
- There may, consequently, come a time when the question of whether to continue treatments becomes an issue. In some cases, refusal of treatment may indicate depression and feelings of hopelessness, but in many cases, the patient's decision may be supported by thoughtful choice.

THE ISSUE OF NONTRADITIONAL TREATMENT

- As both health and communication deteriorate, some terminally ill patients turn away from traditional medical care.
- Many such patients fall victim to dubious remedies offered outside the formal health care system. Frantic family members, friends who are trying to be helpful, and patients themselves may scour fringe publications for seemingly effective remedies or cures; they may invest thousands of dollars in their generally unsuccessful search.
- Some patients are so frantic at the prospect of death that they will use up both their own savings and those of the family in the hope of a miracle cure.
- In other cases, turning to nontraditional medicine may be a symptom of a deteriorating relationship with the health care system and the desire for more humanistic care.

- This is not to suggest that a solid patient-practitioner relationship can prevent every patient from turning to quackery. However, when the patient is well informed and feels cared for by others, he or she is less likely to look for alternative remedies.

MEDICAL STAFF AND THE TERMINALLY III PATIENT

- Unfortunately, death in the institutional environment can be depersonalized and fragmented.
- Wards may be understaffed, with the staff unable to provide the kind of emotional support a patient needs.
- Hospital regulations may restrict the number of visitors or the length of time that they can stay, thereby reducing the avail-ability of support from family and friends.
- Pain is one of the chief symptoms in terminal illness, and in the busy hospital setting, the ability of patients to get the amount of pain medication they need may be compromised.
- Death in an institution can be a long, lonely, mechanized, painful, and dehumanizing experience.

ALTERNATIVES TO HOSPITAL CARE FOR THE TERMINALLY ILL

- **Hospice Care**

- The idea behind hospice care is the acceptance of death, emphasizing the relief of suffering rather than the cure of illness.
- Hospice care is designed to provide palliative care and emotional support to dying patients and their family members.
- Patients are encouraged to personalize their living areas as much as possible by bringing in their own familiar things. Thus, in institutional hospice care, each room may look very different, reflecting the personality and interests of its occupant.

- Patients also typically wear their own clothes and determine their own activities. Hospice care is oriented toward improving a patient's social support system.
- Restrictions on visits from family or friends are removed as much as possible. Staff are especially trained to interact with patients in a warm, emotionally caring way.
- Usually, counselors are available for individual, group, or family intervention.

❑ **Home Care**

- Recent years have seen renewed interest in homecare for dying patients.
- Home care appears to be the care of choice for most terminally ill patients and for many patients, it may be the only economically feasible care.
- The psychological advantages of home care are that the patient is surrounded by personal items and by family rather than medical staff.
- Some degree of control can be maintained over such activities as what to eat or what to wear. Although home care is often easier on the patient psychologically, it can be very stressful for the family.
- Even if the family can afford around-the-clock nursing, often at least one family member's energies must be devoted to the patient on an almost full-time basis.
- The designated caregiver must often stop working and also face the additional stress of constant contact with the prospect of death.
- The caregiver may be torn between wanting to keep the patient alive and wanting the patient's and their own suffering to end.

INDIVIDUAL COUNSELLING

- Counselors working with terminally ill individuals work in a multi-disciplinary team to provide psychological comfort to the dying and their family. They may normalize emotions during a difficult time, provide spiritual support, educate about normal physical, emotional, and social changes, and assist in managing practical problems.
- Counseling Tasks of counselors include helping the dying individual prepare for the reality of death. This is done through education and supportive therapeutic interventions about the dying process that address the physical, emotional, social, spiritual, and practical needs.

FAMILY THERAPY

- The family responds in many ways to this anxiety, but will often not express these feelings; the therapist has to try to discover at which stage of mourning the family has arrived.
- The patient too must be encouraged to express his feelings; this will relieve tension, and make it easier for the family to accept the reality of what is going to happen.
- It is important to keep the family informed about the medical requirements of the treatment.
- These should be explained very clearly, so that all members understand, accept and cooperate in such tasks as ensuring attendance at out-patient consultations, laboratory investigations and taking the medicine prescribed.
- We find that often only one member of the family, usually the mother, carries the whole responsibility of caring for the patient.
- All these matters need to be discussed with the whole family, together with such matters as the patient's school attendance, any problems of family relationships, and plans for the future.

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