Psychological aspects of illness

Sick role & illness behavior

The adjustment depend on patients beliefs about their illness &its effects on their lives. The appraisal of patients of their illness may be very different from that of their doctors because it is based on false information or on emotions rather than facts or is influenced by their cultural beliefs. The appraisal may be reinforced by members of the family who share the patient view or it may be contradicted by them.

The illness behavior

Mechanic in 1978 suggested the term illness behavior for behavior that associated with adjustment to physical or mental illness whether adaptive or not.

It includes consulting doctors, taking medicines, seeking help from relatives& friends& giving up inappropriate activities. It result of patient conviction that he or she is ill rather than from the objective presence of disease.

These behavior are adaptive in the early stages of illness but may become maladaptive if they persist into the stage of convalescence when the patient should be becoming independent.

Illness behavior without disease is an important problem in general practice &once firmly established it is difficult to treat.

The sick role

Parsons in 1951 stated that society bestows a special role for people who are ill.

The sick role is made up of 2 privileges & 2 duties.

1-Exemption from certain social responsibilities.

2-The right to expect help& care from others.

3-The obligation to seek &cooperate with treatment.

4-The expectation of desire to recover.

Adjustment to the onset of physical illness

When people become physically ill they may feel anxious, depressed or angry. Usually this emotional reaction is transient, subsiding as the patient come to terms with the new situation. Denial or minimization can protect the patient against overwhelming anxiety but can be maladaptive in early stage of illness because it may lead to delay in seeking help & at later stage, it may lead to poor compliance with treatment.

Coping strategies can be divided into emotion-reducing that are often appropriate in the early stages of illness& problem-solving coping that is more appropriate in the later stage.

Coping may fail when demands are very great or when coping resources are limited.

Adjustment to terminal illness

50% of dying patients have emotional symptoms. The determinants of emotional reaction include the patients personality& the amount and quality of support provided by the family, friends& carers.

1-Anxiety (irrational fear) may be provoked by sever pain, disfigurement, incontinence fear of death& by concern about the future of the family.

2-Depression, may be provoked by the prospect of separation from family &friends, loss of valued activities, change in physical appearance & debilitating effects of radiotherapy.

3-Guilt can be the result of patients believe that they are making excessive demands on relatives or friends or illness is a punishment for a previous wrong doing.

4-Anger may be felt about unjustness of impeding death. It may be displaced onto doctors, nurses &relatives that is making care more difficult.

5-Defence mechanisms include denial, dependency, displacement &acceptance.

Kubler-Ross in 1969 described 5 phases of psychological adjustment to death. The phases do not necessarily occur in the same sequence &some may not occur at all.

1-Denial

2-Anger

3-Bargaining

4-Depression

5-Acceptance