Human Behaviour in Illness

NSG 215

University of Ibadan Distance Learning Centre
Open and Distance Learning Course Series Development

ISBN 978-021-827-0

General Editor: Prof. Bayo Okunade

University of Ibadan Distance Learning Centre
University of Ibadan,
Nigeria

Telex: 31128NG

Tel: +234 (80775935727)
E-mail: ssu@dlc.ui.edu.ng
Website: www.dlc.ui.edu.ng

Vice-Chancellor's Message

The Distance Learning Centre is building on a solid tradition of over two decades of service in the provision of External Studies Programme and now Distance Learning Education in Nigeria and beyond. The Distance Learning mode to which we are committed is providing access to many deserving Nigerians in having access to higher education especially those who by the nature of their engagement do not have the luxury of full time education. Recently, it is contributing in no small measure to providing places for teeming Nigerian youths who for one reason or the other could not get admission into the conventional universities.

These course materials have been written by writers specially trained in ODL course delivery. The writers have made great efforts to provide up to date information, knowledge and skills in the different disciplines and ensure that the materials are user-friendly.

In addition to provision of course materials in print and e-format, a lot of Information Technology input has also gone into the deployment of course materials. Most of them can be downloaded from the DLC website and are available in audio format which you can also download into your mobile phones, IPod, MP3 among other devices to allow you listen to the audio study sessions. Some of the study session materials have been scripted and are being broadcast on the university's Diamond Radio FM 101.1, while others have been delivered and captured in audio-visual format in a classroom environment for use by our students. Detailed information on availability and access is available on the website. We will continue in our efforts to provide and review course materials for our courses.

However, for you to take advantage of these formats, you will need to improve on your I.T. skills and develop requisite distance learning Culture. It is well known that, for efficient and effective provision of Distance learning education, availability of appropriate and relevant course materials is a *sine qua non*. So also, is the availability of multiple plat form for the convenience of our students. It is in fulfilment of this, that series of course materials are being written to enable our students study at their own pace and convenience.

It is our hope that you will put these course materials to the best use.

Prof. Abel Idowu Olayinka
Vice-Chancellor

Foreword

As part of its vision of providing education for "Liberty and Development" for Nigerians and the International Community, the University of Ibadan, Distance Learning Centre has recently embarked on a vigorous repositioning agenda which aimed at embracing a holistic and all encompassing approach to the delivery of its Open Distance Learning (ODL) programmes. Thus we are committed to global best practices in distance learning provision. Apart from providing an efficient administrative and academic support for our students, we are committed to providing educational resource materials for the use of our students. We are convinced that, without an up-to-date, learner-friendly and distance learning compliant course materials, there cannot be any basis to lay claim to being a provider of distance learning education. Indeed, availability of appropriate course materials in multiple formats is the hub of any distance learning provision worldwide.

In view of the above, we are vigorously pursuing as a matter of priority, the provision of credible, learner-friendly and interactive course materials for all our courses. We commissioned the authoring of, and review of course materials to teams of experts and their outputs were subjected to rigorous peer review to ensure standard. The approach not only emphasizes cognitive knowledge, but also skills and humane values which are at the core of education, even in an ICT age.

The development of the materials which is on-going also had input from experienced editors and illustrators who have ensured that they are accurate, current and learner-friendly. They are specially written with distance learners in mind. This is very important because, distance learning involves non-residential students who can often feel isolated from the community of learners.

It is important to note that, for a distance learner to excel there is the need to source and read relevant materials apart from this course material. Therefore, adequate supplementary reading materials as well as other information sources are suggested in the course materials.

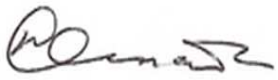
Apart from the responsibility for you to read this course material with others, you are also advised to seek assistance from your course facilitators especially academic advisors during your study even before the interactive session which is by design for revision. Your academic advisors will assist you using convenient technology including Google Hang Out, You Tube, Talk Fusion, etc. but you have to take advantage of these. It is also going to be of immense advantage if you complete assignments as at when due so as to have necessary feedbacks as a guide.

The implication of the above is that, a distance learner has a responsibility to develop requisite distance learning culture which includes diligent and disciplined self-study, seeking available administrative and academic support and acquisition of basic information technology skills. This is why you are encouraged to develop

your computer skills by availing yourself the opportunity of training that the Centre's provide and put these into use.
In conclusion, it is envisaged that the course materials would also be useful for the regular students of tertiary institutions in Nigeria who are faced with a dearth of high quality textbooks. We are therefore, delighted to present these titles to both our distance learning students and the university's regular students. We are confident that the materials will be an invaluable resource to all.

We would like to thank all our authors, reviewers and production staff for the high quality of work.

Best wishes.



Professor Bayo Okunade
Director

Course Development Team

Content Authoring	Mrs. Titilayo D. Odetola and Mrs. Adeyinka G. Ishola
Content Editor	Prof. Remi Raji-Oyelade
Production Editor	Ogundele Olumuyiwa Caleb
Learning Design/Assessment Authoring	SkulPortal Technology
Managing Editor	Ogunmefun Oladele Abiodun
General Editor	Prof. Bayo Okunade

Table of Contents

Content Authoring Mrs. Titilayo D. Odetola and 6
Mrs. Adeyinka G. Ishola 6
Study Session 1: Introduction to human behavior and illness 13
Introduction 13
Learning outcomes for study session 13
1.1 The concepts of behavior, health and illness 13
In-Text Question 14
In-Text Answer 14
In-Text Question 14
In-Text Answer 14
In-Text Question 14
In-Text Answers 14
1.2 Determinants of health 16
1.3 Factors that influence health behaviors: the Health Belief Model 18
In-Text Question 20
In-Text Answer 20
Summary 21
Self-Assessment Questions (SAQs) for Study Session 1 22
SAQ 1.1 (Testing Learning outcomes 1.1) 22
SAQ 1.2 (Testing Learning outcomes 1.2) 22
SAQ 1.3 (Testing Learning outcomes 1.3) 23
Notes on SAQs for study session 1 23
SAQ 1.1 23
SAQ 1.2 23
SAQ 1.3 23
References 24
Study Session 2: Illness and Disease 25
Introduction 25
Learning outcomes for study session 2 25
2.1 Concept of Illness and disease 25
2.2 Classes of illness and disease 27
In-Text Question 28
In-Text Answer 28
2.2.1 Stages of Illness 28
In-Text Question 32
In-Text Answer 32
2.2.2 Differences between illness and disease 32
2.3 Illness behaviors in childhood, adolescence, and adulthood 33
Self-Assessment Questions (SAQs) for Study Session 2 34
SAQ 2.1 (Testing Learning outcomes 2.1) 35
SAQ 2.2 (Testing Learning outcomes 2.2) 35
SAQ 2.3 (Testing Learning outcomes 2.3) 35
Notes on SAQs for study session 2 35
SAQ 2.1 35

SAQ 2.2 ... 35
SAQ 2.3 ... 35
References ... 36
Introduction ... 37
Learning Outcomes for study session 3 ... 37
3.1 Medication Adherence ... 37
3.2 Assessing Medication Adherence ... 38
In-Text Question ... 39
In-Text Answer ... 39
3.3 Medication non adherence ... 39
In-Text Question ... 41
In-Text Answer ... 41
3.4 Nurses' responsibilities in ensuring adherence ... 41
Summary ... 42
SAQ 3.1 (Testing Learning outcomes 3.1) ... 43
SAQ 3.2 (Testing Learning outcomes 3.2) ... 43
SAQ 3.3 (Testing Learning outcomes 3.3) ... 43
SAQ 3.4 (Testing Learning outcomes 3.4) ... 43
Notes on SAQs for study session 3 ... 44
SAQ 3.1 ... 44
SAQ 3.2 ... 44
SAQ 3.3 ... 44
References ... 45
Study Session 4: Illness Cognition ... 46
Introduction ... 46
Learning Outcomes for study session 4 ... 46
4.1 Illness and healthiness ... 46
In-Text Question ... 47
In-Text Answer ... 47
4.2 Illness Cognition ... 47
In-Text Question ... 48
In-Text Answer ... 48
4.3 Concept of disease causation ... 48
In-Text Question ... 49
In-Text Answer ... 49
4.4 Models of disease causation ... 49
4.5 Patterns of Illness ... 51
Summary ... 52
SAQ 4.1 (Testing Learning outcomes 4.1) ... 53
SAQ 4.2 (Testing Learning outcomes 4.2) ... 53
SAQ 4.3 (Testing Learning outcomes 4.3) ... 53
SAQ 4.4 (Testing Learning outcomes 4.4) ... 53
SAQ 4.5 (Testing Learning outcomes 4.5) ... 54
Notes on SAQs for study session 4 ... 54
SAQ 4.1 ... 54
SAQ 4.2 ... 54

SAQ 4.3 54
SAQ 4.4 54
SAQ 4.5 55
References 55
Study Session 5: Coping models with adaptation to illness 56
Introduction 56
Learning outcomes for study session 5 56
5.1 Coping 56
5.2 Coping model in the context of adaptation to illness 57
5.2.1 The transactional model of stress and coping 57
In-Text Question 60
In-Text Answer 60
5.3 Responses to stress Model 60
In-Text Question 61
In-Text Answer 61
5.4 Motivational Model of Coping 61
In-Text Question 63
In-Text Answer 63
5.5 The Community Stress Prevention Model 63
Summary 64
SAQ 5.1 (Testing Learning outcomes 5.1) 65
SAQ 5.2 (Testing Learning outcomes 5.2) 65
SAQ 5.3 (Testing Learning outcomes 5.3) 65
SAQ 5.4 (Testing Learning outcomes 5.4) 65
SAQ 5.5 (Testing Learning outcomes 5.5) 66
Notes on SAQs for study session 5 66
SAQ 5.1 66
SAQ 5.2 66
SAQ 5.3 66
SAQ 5.4 66
SAQ 5.5 66
References 67
Study Session 6: Coping response 68
Introduction 68
Learning Outcomes for study session 6 68
6.1 Coping responses 68
In-Text Question 69
In-Text Answer 70
6.2 Stages of responses in illness 70
6.3 Coping with a diagnosis 72
In-Text Question 73
In-Text Answer 73
6.4 Coping and culture 73
Self-Assessment Questions (SAQs) for Study Session 6 76
SAQ 6.1 (Testing Learning outcomes 6.1) 76
SAQ 6.2 (Testing Learning outcomes 6.2) 76

SAQ 6.3 (Testing Learning outcomes 6.3) 76
SAQ 6.4 (Testing Learning outcomes 6.4) 76
Notes on SAQs for study session 6 76
SAQ 6.1 76
SAQ 6.2 77
SAQ 6.3 77
SAQ 6.4 77
References 78
Study Session 7: Coping with the crisis of illness 79
Introduction 79
Learning outcomes for study session 7 79
7.1 Crisis Theory 79
7.2 Ego Defense Mechanism 81
In Text Question 81
In Text Answer 81
In Text Question 83
In Text Answer 83
7.3 Types of Defense Mechanism 83
In Text Question 84
In Text Answer 84
7.4 Grief and Mourning 85
In Text Question 86
In Text Answer 86
7.5 Responses of clients and their families to terminal illness and Impending death. 86
In Text Question 87
In Text Answer 87
7.6 Assessment of the Grieving Client 88
7.7 Factors That Influence Coping During the Grieving Process 89
In Text Question 90
In Text Answer 90
7.8 Grief is a family matter 90
In-Text Question 93
In-Text Answer 93
SAQ 7.1 (Testing Learning outcomes 7.1) 93
SAQ 7.2 (Testing Learning outcomes 7.2) 93
SAQ 7.3 (Testing Learning outcomes 7.3) 93
SAQ 7.4 (Testing Learning outcomes 7.4) 93
SAQ 7.5 (Testing Learning outcomes 7.5) 93
SAQ 7.6 (Testing Learning outcomes 7.6) 93
SAQ 7.7 (Testing Learning outcomes 7.7) 94
SAQ 7.8 (Testing Learning outcomes 7.8) 94
Notes on SAQs for study session 7 94
SAQ 7.1 94
SAQ 7.2 94
SAQ 7.3 94

SAQ 7.4 94
SAQ 7.5 94
SAQ 7.6 94
SAQ 7.7 95
SAQ 7.8 95
References 95
Study Session 8: Influences on the sick 96
Introduction 96
Learning outcomes for study session 8 96
8. 1 Domains of the patient's life affected by chronic illness 96
In-Text Question 98
In-Text Answer 98
8.2 Impact of chronic illness on families. 99
8.3 Factors influencing how families will respond to chronic illness 100
In-Text Question 102
In-Text Answer 102
8.4 Reactions to Hospitalization across ages 102
In-Text Question 103
In-Text Answer 103
8.5 Role of the nurse during and at the end of hospitalization 104
In-Text Question 105
In-Text Answer 106
Self-Assessment Questions (SAQs) for Study Session 8 106
SAQ 8.1 (Testing Learning outcomes 8.1) 107
SAQ 8.2 (Testing Learning outcomes 8.2) 107
SAQ 8.3 (Testing Learning outcomes 8.3) 107
SAQ 8.4 (Testing Learning outcomes 8.4) 107
SAQ 8.5 (Testing Learning outcomes 8.5) 107
Notes on SAQs for study session 8 107
SAQ 8.1 107
SAQ 8.2 107
SAQ 8.3 107
SAQ 8.4 107
SAQ 8.5 108
References 108

Course Information

Course Code & Course Name: NSG 215: Human Behavior and Illness

Credit points: 3 Units

Year: 200-Level; Semester: First Semester

About the Course: This course is designed to help students acquire the knowledge of socio- psychological determinants of human behavior. Such behaviors as compliance, resistance and utilization will also be examined in terms of health/ illness continuum.

Lecturer Information:

- **Facilitators: Mrs. Titilayo D. Odetola and Mrs. Adeyinka G. Ishola**
- **Email: odetolatitilayo@yahoo.com; adeyinkaishola2004@yahoo.com**
- **Consultation: Through SMS, email and facebook.**

Introduction to the Course:

You are welcome to NSG 215. This is an online course that runs in the distance learning mode. It is a compulsory course open to all nursing students and it is a 3-unit course that has 45 hours of interaction among teachers and learners for the period of the course.

Aim: The course aims at introducing concepts of behavior, health and illness; identify the determinants of human behavior and describe illness behavior and various models of human behavior in illness.

Study Session 1: Introduction to human behavior and illness

Introduction

Health they say is wealth. Most individuals want to stay healthy. However not everybody is healthy. Our health status could be determined by ourselves, our behaviors and traits. Health professionals have discovered the need to help people on how to stay healthy.

Therefore in this study you will learn the concepts of behavior, health and illness. You will also understand the determinants of health, and factors that influence health behaviors using the health belief model.

Learning outcomes for study session

At the end of this study, you should be able to:

1.1. Explain the concepts of behavior, health and illness
1.2. Discuss the determinants of health
1.3. Highlight the factors that influence health behaviors: health belief model.

1.1 The concepts of behavior, health and illness

There is need to understand the concept of behavior as it relates to health and illness. Health educators must understand what motivates human behavior. Alcohol, drug addiction, smoking, obesity, venereal disease are just a few of the hundreds of pathological states which result from human responses (behavior). Terms like disease, value and attitude will also be discussed to help you understand these concepts.

Behavior

Behavior is the response of an individual or group to an action, environment, person, or stimulus. A behavior is simply defined as a persons' way of responding or reacting in different situations. It is called a behavior if such has become a persistent way of reacting being monitored over a period of time.

Box 1.1 Definition of Behavior

Behavior is the response of an individual or group to an action, environment, person, or stimulus

Disease

A disease is a definite strange condition, a disorder of outlook or function that affects part or all of an organism. The failure of a part or the entire organism to function effectively can be attributed to germs or hereditary factors. Culture also has a great influence on the community's view of disease. Some communities attribute the incidence of disease to witchcraft, sorcery, and mystical forces.

In-Text Question

----------is a definite strange condition, a disorder of outlook or function that affects part or all of an organism

In-Text Answer

A disease

Value

Value is a norm or standard, as of behavior, that is considered vital or appropriate.

Value is a belief upon which a person acts by preference.

In-Text Question

The norm or standard as of behavior that is considered vital or appropriate is_____

In-Text Answer

Value

Attitude

This is the manner, disposition with regard to a person or thing; orientation, especially of the mind. It is a mental and neural state of readiness, organized through exposure, extending a dynamic influence upon the individual's response to all objects and situations with which it is related. Thus an individual's values affect a wide range of thought and behavior patterns thereby generating attitudes.

In-Text Question

A person's individual values affect a wide range of thought, behavior patterns and generates_____

In-Text Answers

Attitudes

Health

According to the World Health Organization's definition, health is defined as a state of physical, mental, psycho-social and spiritual well- being and not merely the absence of diseases. Health can also be said to mean the level of useful or metabolic efficiency of a living organism.

The image below is the logo of the World Health organization whose efinition of health was given

Figure 1.1 *World Health Organization's logo*
http://upload.wikimedia.org/wikipedia/commons/5/51/Who-logo.jpg

Illness

Illness refers to any state of disturbance in normal functioning of total human individual including both the state of the organism as a biological system and his personal and social adjustment. It may be acute or chronic.

The figure below is a picture of critically ill children

Figure 1.2 *Critically ill children*
Sourece:*http://www.rockcellarmagazine.com/wp-content/uploads/2013/02/Starving-Children-Africa-Toto.jpg*

In unit 1.1, you have been given the definitions of different health concepts. In this unit, you will be taken through the determinants of health and how our activities affect our health.

1.2 Determinants of health

There are several factors that determine the state of health of individuals in a community. Such factors could be:

- the social and economic environment,
- the physical environment
- the person's individual characteristics and behaviors

Figure 1.3: *Factors determining the state of health*

These factors can be broken down to:

1. Income and social status
2. Education
3. Physical environment
4. Employment and working conditions
5. Social support networks
6. Genetics
7. Health services
8. Gender

Income and social status: The higher the income, the better the state of health. Poor income can make individuals not to attend to their health. Individuals with high social standing usually have access to good health care.

Education: A person's low education could affect his state of health. It could result to inadequate response to health issues due to ignorance.

Physical environment: It has been discovered that safe water, clean air, healthy offices, safe houses, communities and roads contribute to healthier living.

Employment and working conditions: Employed individuals and people with good working conditions live healthy.

Social support networks: The support of family and friends mean a lot and could enhance healthy living.

Culture: Healthy customs and traditions, and the beliefs of the family and community could also enhance healthy living.

Genetics: The genetics of an individual could determine if he is vulnerable to certain sicknesses or diseases.

Health services: Availability and use of services that prevent and treat disease influences health.

Gender: Some diseases are gender based.

Personal behavior: Some behaviors exhibit by individuals could affect their state of health. For example, eating and sleeping habit.

Some of such behaviors are categorized below.

- Health- motivated behavior
- Non- health motivated behavior
- Risk- motivated behavior
- Conflict- motivated behavior

Health- motivated behavior

Some stimuli will motivate the individual to care for or reflect on his/ or her health status positively or otherwise. For example, a sudden toothache may prompt a person to visit a dentist for treatment (disease/ illness prevention).

Non- health motivated behavior

Sometimes people do things that affect their health, but which are not motivated by health reasons. For example, having white and healthful gums will make individuals look attractive and will leave a good taste in the mouth. Therefore, one may develop the habit of brushing the teeth for aesthetic reasons, and not really because of preventing tooth decay. However, the result of this behavior is positive.

Risk- motivated behavior

Sometimes people engage in behaviors that they are aware of the health risks involved, but are willing to take the risk. Many individuals who consume drugs are probably aware of the dangers inherent and the damage they may do to their bodies. They listen to educational messages on radio and television programs, yet they go ahead to consume illegal drugs.

Conflict- motivated behavior

Another variable that must be considered even in the individual who is highly motivated toward positive health behavior is that of conflicting motives. Many students know the dangers of using drugs and other mood modifiers, yet they participate in illicit drug activities, so as not to be disliked by their peers who are also involved.

Activity 1.1 Health behaviors

Time Allowed: 5 days

Observe the behavior of someone around you for five days and identify what motivated him/ her to behave in certain ways and how you think that person will respond to his/her health.

1.3 Factors that influence health behaviors: the Health Belief Model

Health behavior is the action taken by a person to sustain, reach, or regain good health and to check illness. Health behavior reveals a person's health beliefs.

The focus of the health belief model is the prevention of disease, rather than the control after it has started. The model emphasizes motivation and the historical perspective of the individual based on his/ her prior experiences. Thus, current dynamics confronting the individual are emphasized as well as all the factors that motivate behavior.

It is a recognized fact that health and well- being hold a relatively low priority in the value complex of most individuals who are in good health. When a person is in good health, disease is rarely thought about or examined. So disease holds a more or less neutral position in the scheme of things.

The health- belief model proposes that the individual will take action (exhibit a behavior) to avoid disease if two conditions are met-

1. The individual's belief of susceptibility to a particular disease condition. The range of vulnerability as perceived by the individual varies greatly and may be viewed on a spectrum. There are thus two positions available. On one end is the individual who denies any possibility of involvement with the disease process, and at the other end is the person who expresses a feeling of real danger of contracting a specific disease.

2. The belief that the occurrence of the disease would have a moderately severe impact on some aspects of the individual's life. Just as the acceptance of personal vulnerability to a specific condition varies from one person to another, so does the individual's perception of its seriousness varies.

   If these two conditions are met, the individual must then believe that a particular course of action (behavior) would be beneficial. The behavior would have value if it

reduces individual's susceptibility to the disease or reduces the severity of the condition if it already exists.

A serious consideration must also be given to the barriers, which prevent the individual from this constructive behavior.

These factors include:

(a) Internal factors of pain and embarrassment

(b) External factors of cost and convenience.

From a broader perspective, the individual's perception of the seriousness of the threat is an important inducement for a positive pattern of behavior. The disease would be considered a threat if it adversely affects a person's job or ability to support his family.

The probability of that person being able to **take appropriate course of action** (behavior) is further **influenced by** asset of intervening variables or modifying **factors** which include such elements as demographic characteristics (of age, sex and race), socio-psychological variables (of personal traits, social class, peer and reference groups) and structural variables (a mental components), all of which affect health behavior.

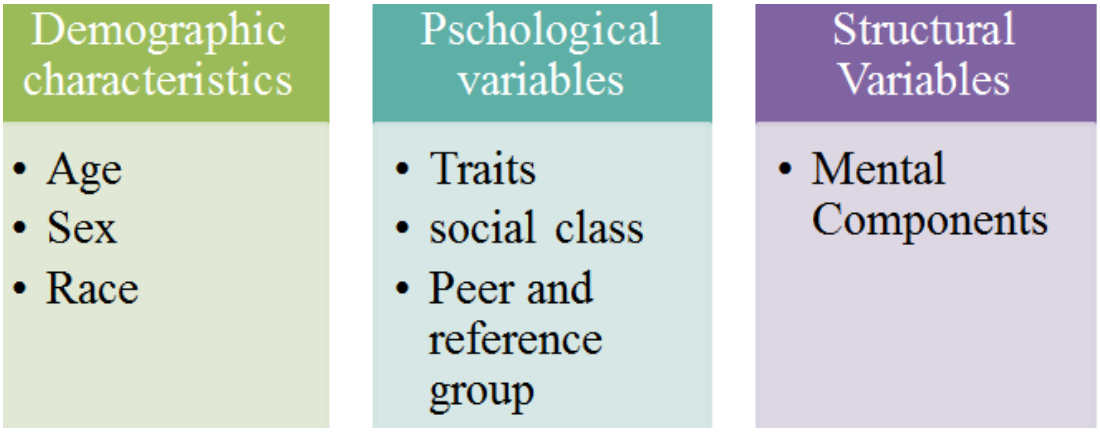


Figure 1.4 *Factors influencing health behavior*

Knowledge of a disease, prior contact with it, and other considerations that increase the level of knowledge of the disease inevitably influence the pattern of health behavior.

Just as demographic, psychosocial and structural variables constitute one set of factors modifying health behavior, an additional set exists, which constitute an essential ingredient in the mode of behavior.

This set of factors called "**cues to action"** triggers or initiates appropriate health behavior. Such modifying cues may include mass media campaign, advice from others, and illness of family member or friend.

The final phase of the health belief model is the likelihood of action.

The likelihood of action being taken is enhanced when the benefit of taking this action is realized. Barriers also exist to prevent the individual from initiating this action. The likelihood of a positive action is thus estimated in terms of the perceived benefits of the action minus the barriers that prevent it from occurring.

This means that an individual may see he/ she susceptible to a serious disorder and may also be considered that no alternative exist to alleviate the problem. Or an individual may believe that an action will be effective in reducing the threat of disease, but the action involved may be costly, inconvenient and painful. If readiness to act is high, and the corresponding barrier to the action is low, the probability for action will be high.

Conversely too, if the individual is not ready to act, and the barrier to act was high, the action (positive behavior) would not occur. But should an equal level exist on both variables (high readiness to act and high barrier to action) the conflict becomes very difficult to solve.

In-Text Question

The probability of a person being able to take appropriate course of action (behavior) is influenced by asset of intervening variables or modifying factors which include the following except

(a) Demographic characteristics (b) socio- psychological variables(c) structural variables (d) Meta-physical variables

In-Text Answer

(d) Meta-physical variables

The diagrammatic expression of health behavior model (HBM) as postulated by Rosenstock.

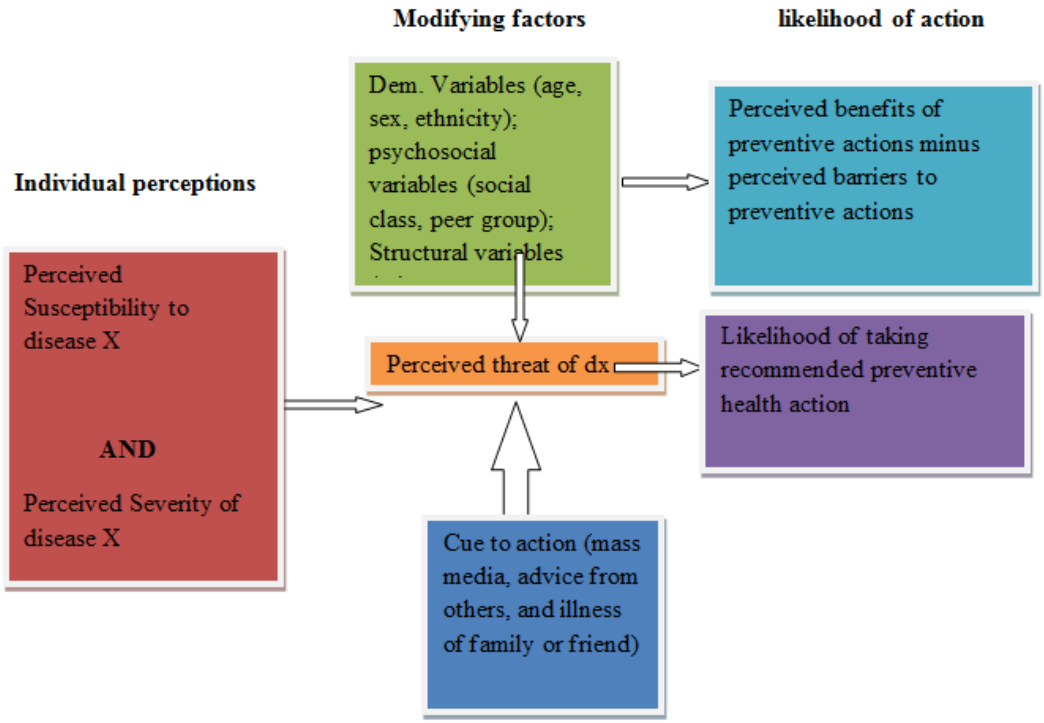


Figure 1.5 Health behavior model diagram

Summary

In study session 1, you have learnt that:

1. Behavior is the response of an individual or group to an action, environment, person, or stimulus.
2. A disease is a definite strange condition, a disorder of outlook or function that affects part or all of an organism.
3. Value is a norm or standard, as of behavior, that is considered vital or appropriate
4. Attitude is the manner, disposition with regard to a person or thing; orientation, especially of the mind.
5. According to the World Health Organization's definition, health is defined as a state of physical, mental, psycho-social and spiritual well- being and not merely the absence of diseases.
6. Illness refers to any state of disturbance in normal functioning of total human individual including both the state of the organism as a biological system and his personal and social adjustment.
7. Some of the factors determining health include:
    - the social and economic environment,
    - the physical environment, and
    - the person's individual characteristics and behaviors

8. Some behaviors exhibit by individuals could affect their state of health.
   Such behaviors include:
   - Health- motivated behavior
   - Non- health motivated behavior
   - Risk- motivated behavior
   - Conflict- motivated behavior
9. Health- motivated behavior involves individuals being motivated by some stimuli to care for or reflect on his/ or her health status positively or otherwise.
10. Risk- motivated behavior involves engaging in behaviors that they are aware of the health risks involved, but are willing to take the risk
11. Conflict- motivated behavior involves individual who is highly motivated toward positive health behavior and conflicting motives
12. The health- belief model contends that the individual will take action (exhibit a behavior) to avoid disease if two conditions are met. They are:
13. The individual's belief of susceptibility to a particular disease condition
14. The belief that occurrence of the disease would have a moderately severe impact on some aspects of the individual's life
15. A serious consideration must also be given to the barriers, which prevent an individual from constructive behavior
16. Factors that prevent an individual from constructive behavior include:
    a. Internal factors of pain and embarrassment
    b. External factors of cost and convenience.

17. The final phase of the health belief model is the likelihood of action
18. The likelihood of action being taken is enhanced when the benefit of taking this action is realized.

Self-Assessment Questions (SAQs) for Study Session 1

Now that you have completed this study session, you can assess how well you have achieved its Learning outcomes by answering the following questions.

Write your answers in your study Diary and discuss them with your Tutor at the next study Support Meeting.

You can check your answers with the Notes on the Self-Assessment questions at the end of this Module.

SAQ 1.1 (Testing Learning outcomes 1.1)

How can we define human behavior?

SAQ 1.2 (Testing Learning outcomes 1.2)

Mention some of the factors that determine the state of health of individuals in a community and personal behaviors that could equally affect the state of health

SAQ 1.3 (Testing Learning outcomes 1.3)

The health- belief model proposes that the individual will take action (exhibit a behavior) to avoid disease if two conditions are met. What are the conditions?

Notes on SAQs for study session 1

SAQ 1.1

Behavior is the response of an individual or group to an action, environment, person, or stimulus.

SAQ 1.2

Some of the factors that determine a person's state of health include:

1. Income and social status
2. Education
3. Physical environment
4. Employment and working conditions
5. Social support networks
6. Genetics
7. Health services
8. Gender

Such personal behaviors include:

- Health- motivated behavior
- Non- health motivated behavior
- Risk- motivated behavior
- Conflict- motivated behavior

SAQ 1.3

It involves the individual's belief of susceptibility to a particular disease condition. The range of vulnerability as perceived by the individual varies greatly and may be viewed on a spectrum. There are thus two positions available. On one end is the individual who denies any possibility of involvement with the disease process, and at the other end is the person who expresses a feeling of real danger of contracting a specific disease.

The second condition is the belief that the occurrence of the disease would have a moderately severe impact on some aspects of the individual's life. Just as the acceptance of personal vulnerability to a specific condition varies from one person to another, so does the individual's perception of its seriousness varies.

References

- http://www.businessdictionary.com/definition/behavior.html#ixzz3Y2Ox8YMq
- http://www.who.int/hia/evidence/doh/en/
- http://www.ntcu.edu.tw/je0071/Health%20Promotion%20Planning%20Indina/p4p1.htm

Study Session 2: Illness and Disease

Introduction

She walked into the hospital looking weak and pale. You could judge by her looks that she is not her normal self. She is sick. I guess you could have met individuals like this before. That is what illness could do.

In this study session you will learn the concept of illness and disease, the classes of illness and disease and the Illness behaviors in childhood, adolescence, and adulthood.

Learning outcomes for study session 2

At the end of this study, you should be able to:

2.1. Explain the concept of illness and disease
2.2. Highlight the classes of illness and disease
2.3. Discuss the illness behaviors in children, adolescence and adulthood.

2.1 Concept of Illness and disease

Illness is a condition of being unhealthy in your body and mind. It is an exact condition that prevents your body or mind from working normally. Illness is a state of being unwell. It is the level of depth of disease manifestation in an individual.

Illness can also be defined as an unusual process in which aspects of the social, physical, emotional, or intellectual condition and function of a person are weakened or impaired compared with that person's previous condition.

Illness is a state in which the person’s physical, emotional, intellectual, social, developmental or spiritual functioning is thought to be diminished. Illness brings about a change in individuals and has short or long term effect on the normal activities of daily living and survival.

The figure below shows a critically ill child

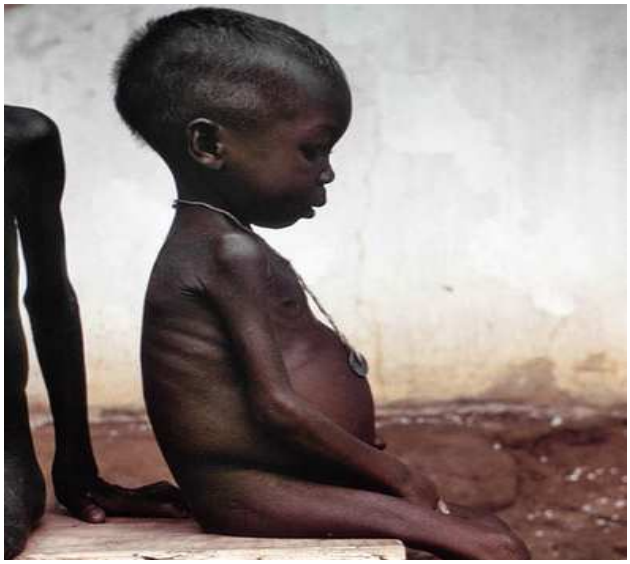


Figure 1.1 critically ill child

Source:
http://upload.wikimedia.org/wikipedia/commons/thumb/4/47/Starved_girl.jpg/505px-Starved_girl.jpg

Illness is the major reason why an individual is hospitalized and thus poses great threat to the person, the family and the society at large. Hospitalization is a word used interchangeably with admission into a hospital on account of illness or a deviation toward the left on the health- illness scale.

Box 1.1: Definition of illness

Illness is a highly personal state in which the person's physical, emotional, intellectual, social, developmental or spiritual functioning is thought to be diminished

Diseases

Disease is an interruption, termination, or disorder of a body, system, or organ structure or function. A disease is a definite strange condition, a disorder of outlook or function that affects part or all of an organism.

The figure below shows a boy affected by disease on his face

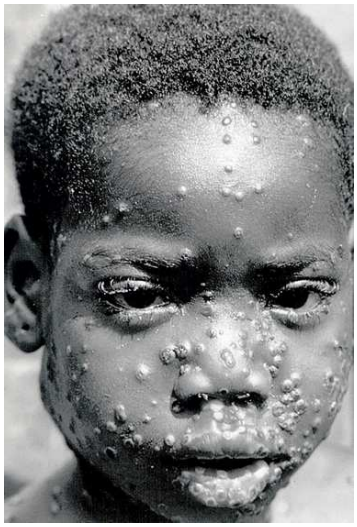


Figure 1.2. *A Boy affected inflicted with a disease*
Source: ***https****://farm8.staticflickr.com/7287/9523369457_867f2efc05_o.jpg*

2.2 Classes of illness and disease

Illness can be **classified** into based on onset (beginning), duration and management. Illness could be:

- Acute Illness
- Chronic illness

Acute Illness

Acute illness is a type of illness that will eventually resolve without any medical supervision. Acute Illness is characterized by severe symptoms of relatively short duration. The symptoms often appear sharply and diminish quickly .It also depends on the cause. It may or may not require intervention by health care professionals e.g. appendicitis and cold.

Chronic illness

Chronic illness is the type of illness that lasts for an extended period, usually six months or longer and often has periods of reduction, when the symptoms disappear and when symptoms re-appear e.g. sickle cell anemia

Chronic illness is a class of illness that has formed over a long period of time in the body. Examples of chronic illnesses are Cancer, AIDS, Kidney Disease and Diabetes. Usually, medicines for chronic illnesses are regulated as Prescription Only.

In-Text Question

_____is the one that lasts for an extended period

In-Text Answer

Chronic illness

2.2.1 Stages of Illness

There are different stages of illness. They are:

- Symptoms experience
- Assumption of the sick role
- Medical care contact
- Dependent client role
- Recovery or rehabilitation

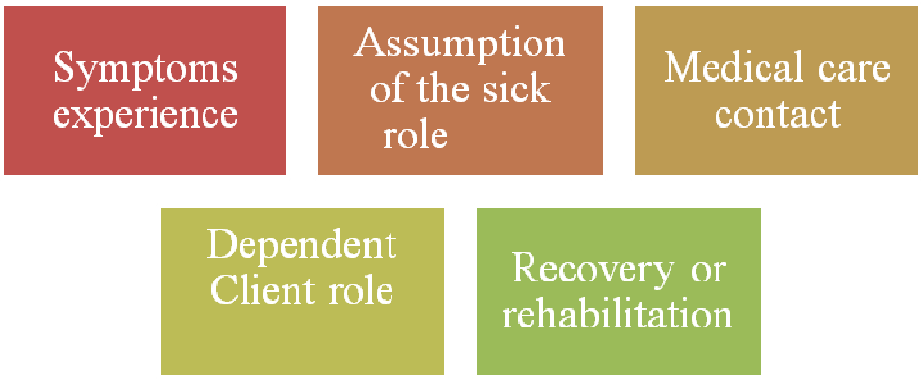


Figure 1.3 *Stages of illness*

Symptoms experience

Symptoms experience could occur when an individual sense physical limitation or knowing of something that is wrong but could not diagnose the problem.

Assumption of the sick role

When symptom continue and turn out to be severe, clients accept the sick role. At this junction, the illness becomes a social phenomenon, and sick people seek approval from their families and social groups that they are certainly ill and that they be exempted from usual duties and role expectations.

Medical care contact

Symptoms may persist despite the home therapies, become severe or require emergency care; the person is encouraged to seek professional health services. In this stage the client seeks expert acknowledgement of the illness as well as the treatment**.**

Dependent client role

The client trust and depend on health care professionals for the relief of symptoms. The client accepts care, empathy and protection from the hassles and pressures of life. A client can adopt the dependent role in a health care institution, at home, or in a community setting. The client must learn to adjust to the disorder of a daily schedule.

Recovery or rehabilitation

This stage shows up suddenly just like when the symptoms shows up. In the case of prolonged illness, the final stage may require an adjustment to a prolong reduction in health and functioning.

Classification of disease

Diseases can be classified into the following types

1. Heart, Lung and Other Organ Diseases
2. Blood and Immune System Diseases
3. Cancer
4. Injury
5. Brain and Nervous System Diseases
6. Endocrine System Diseases
7. Infectious and Parasitic Diseases
8. Pregnancy and Childbirth-Related Diseases
9. Inherited Diseases
10. Environmentally-Acquired Diseases

Heart, Lung and Other Organ Diseases:

Centers for Disease Control and Prevention say heart disease is a number one killer all over the world. Heart attacks, coronary heart disease and congestive heart failure are all common. Lung diseases, such as chronic obstructive pulmonary disease, also cause many deaths. Causes of these ailments, as well as those of other organs, include inherited conditions, infections and trauma.

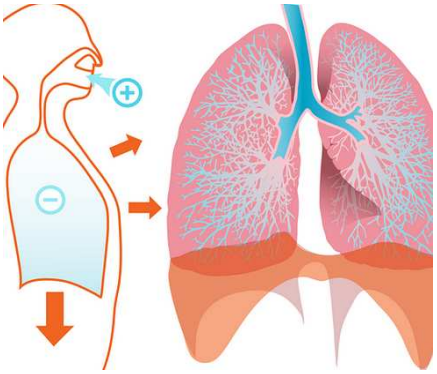


Figure 1.4 *Heart, Lungs action*
Source:*http://pixabay.com/p-41562/?no redirect*

Blood and Immune System Diseases

The function of the immune system (a collection of structures and processes within the body) is to protect against disease or other potentially damaging foreign bodies. When functioning properly, the immune system identifies a variety of threats, including viruses, bacteria and parasites, and differentiates them from the body's own healthy tissue. When it is not functioning well diabetes, rheumatoid arthritis and psoriasis, anemia are commonly noticed.

Cancer

Cancer is a class of disease that develops from cells that cannot be controlled. There are over 100 different types of cancer, and each is classified by the type of cell that is primarily affected. Examples of this include breast cancer, lung cancer and prostate cancer.

The figure below shows a cancerous cell

Figure 1.5: Cancerous cell

Source:http://upload.wikimedia.org/wikipedia/commons/5/53/Secondary_tumor_deposits_in_the_live

Injury

Injury is a general term for damages caused by accidents, falls, hits, weapons, and more. Millions of people injure themselves every year. These injuries range from minor to life-threatening.

Wounds are injuries that break the skin or other body tissues. They include cuts, scrapes, scratches, and punctured skin. They often happen because of an accident, but surgery, sutures, and stitches also cause wounds.

The figure below shows a head injured boy

Figure 1.6 *An Injured child*

Source:*http://upload.wikimedia.org/wikipedia/commons/7/7d/Boy_receiving_treatment_after_Haiti_earthquake.jpg*

Brain and Nervous System Diseases

Brain and nervous system illnesses can appear at any age. It affects the functionality of the brain. Spinal bifida, which is associated with inadequate folic acid intake in a pregnant woman's diet, is present at birth. Alzheimer's dementia, like schizophrenia, arises in adults, has a genetic component and is related with physical changes in the brain

Endocrine System Diseases

Endocrine glands secrete hormones into the bloodstream with great effects. For example, diabetes occurs when insulin from the pancreas can no longer effectively adjust glucose. Cushing's disease of the adrenal glands and hyperthyroidism are also endocrine disorders.

Infectious and Parasitic Diseases

These are diseases transmitted by parasites which live on the body of the host. Examples of such diseases are malaria, tuberculosis. Parasites like virus and bacteria have done a lot of damage on the human body.

Pregnancy and Childbirth-Related Diseases

The rate of child mortality rate is high and this results from childbirth related disease. Pregnancy related diseases are deadly and of the high side. Examples of such diseases include blood clots ,bacterial vaginosis and cellulitis.

Blot cot is an example of pregnancy related disease and is represented in the diagram below

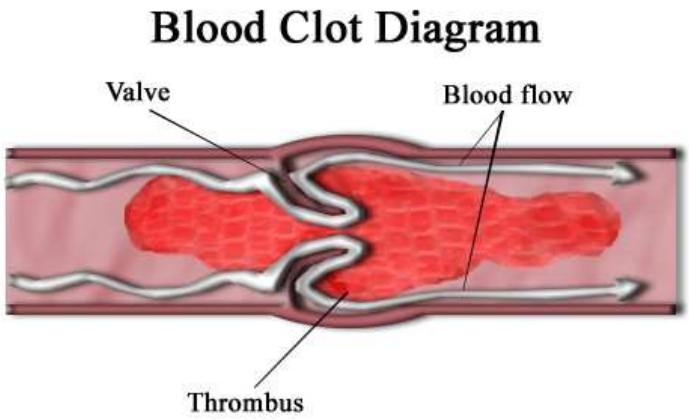


Figure 1.7 *Blot Clot diagram*

Source: *http://upload.wikimedia.org/wikipedia/commons/c/c5/Blood_clot_diagram.png*

Inherited Diseases

Inherited diseases can be the result of a single gene abnormality -- such as sickle cell disease or Down's syndrome -- or from the interplay of multiple genes.

Environmentally-Acquired Diseases

Environmental health effects can be instant, such as heat wave-related deaths or carbon monoxide poisoning. Others, such as skin cancer may take years to develop.

In-Text Question

The different types of disease include the following except

(a) Cancer (b) Injury(c)Brain Nervous System Diseases (d) Trypanosotic disease

In-Text Answer

(d) Trypanosotic disease

2.2.2 Differences between illness and disease

Illness and disease could be related but have some differences. Some of which are highlighted in the table below.

Table 1.1 Differences between illness and disease

Illness	**Disease**
Easily recoverable ailments are considered illnesses	Severe, life-death type treatment are considered diseases
For example fever is considered illness	For example Malaria or jaundice is disease.
Illness is a product of disease	Disease cause illness
You can have illness without disease	You can have disease without illness
Illness is something a man has	Disease is something an organ has

2.3 Illness behaviors in childhood, adolescence, and adulthood

Illness behavior is a concept put forward by sociologists and is seen as a coping mechanism, which involves ways individual describe, monitor and interpret their symptoms, take remedial actions and use the health care system.

Illness behaviors vary from childhood to adulthood. They are discussed below.

Illness Behavior in Childhood

Erik Erickson in his psychosocial theory (1960) divided human development into eight stages. All these stages cover the behavior of an individual from infancy to old age but for the scope of this discussion, it will be limited to the first four stages which are collectively known as childhood.

- Neonates/ infancy (birth - 1 year)
- Toddler (2- 3 years)
- Pre- school (4 – 5 years)
- School Age (6 – 12 years)

Childhood is the period between infancy and puberty i.e. 0- 12 years. The term is non-specific and implies a varying range of years in human development. Children at different developmental stages react differently to illness and subsequently, hospitalization.

The emotional reactions of children also depend on the type and quantity of the stress and tension produced by the illness, hospitalization, misperception about hospitalization and medical procedure.

Illness Behavior in Adolescence

The Adolescence groups which are of age 13 to 19 also reflect some illness behavior. Some of them at this age are susceptible to illness like chronic fatigue syndrome, juvenile rheumatoid arthritis. This age group is more likely to demand independence and this reflect this in the illness behavior.

Illness Behaviors in Adulthood

This reflects the illness behavior of individuals of 20years above (young adult) and 40 years above (mature adult). This age group could exhibit behavioral disorder which could reflect as anxiety, emotional disorder etc.

The adult age group reflects their experience or background which is easily seen in their illness behavioral pattern. Children who grew up witnessing some bad examples in illness behavioral pattern eventually become adults and show similar illness behavioral pattern.

Activity 1.1 Illness behaviors in childhood, adolescence and adulthood

Time Duration: 15 minutes

Discuss the illness behaviors of members of your family.

Summary

In study session 2, you have learnt that:

1. Illness is a condition of being unhealthy in your body and mind
2. Disease is an interruption, termination, or disorder of a body, system, or organ structure or function
3. Illness can be classified into based on onset (beginning), duration and management.
4. Illness could be:
    - Acute Illness
    - Chronic illness
5. Acute illness is a type of illness that will eventually resolve without any medical supervision.
6. Chronic illness is the type of illness that lasts for an extended period, usually six months or longer and often has periods of reduction, when the symptoms disappear and when symptoms re-appear.
7. The different stages of illness are:
    - Symptoms experience
    - Assumption of the sick role
    - Medical care contact
    - Dependent client role
    - Recovery or rehabilitation
8. Illness behavior is a concept put forward by sociologists and is seen as a coping mechanism, which involves ways individual describe, monitor and interpret their symptoms, take remedial actions and use the health care system.

Self-Assessment Questions (SAQs) for Study Session 2

Now that you have completed this study session, you can assess how well you have achieved its Learning outcomes by answering the following questions.

Write your answers in your study Diary and discuss them with your Tutor at the next study Support Meeting.

You can check your answers with the Notes on the Self-Assessment questions at the end of this Module.

SAQ 2.1 (Testing Learning outcomes 2.1)

Define illness and disease

SAQ 2.2 (Testing Learning outcomes 2.2)

Explain the acute and chronic nature of illness

SAQ 2.3 (Testing Learning outcomes 2.3)

Discuss the illness behavior pattern of the childhood group

Notes on SAQs for study session 2

SAQ 2.1

Illness is a state in which the person's physical, emotional, intellectual, social, developmental or spiritual functioning is thought to be diminished

Disease is an interruption, termination, or disorder of a body, system, or organ structure or function.

SAQ 2.2

Acute illness is a type of illness that will eventually resolve without any medical supervision. Acute Illness is characterized by severe symptoms of relatively short duration. The symptoms often appear sharply and diminish quickly.

Chronic illness is the type of illness that lasts for an extended period, usually six months or longer and often has periods of reduction, when the symptoms disappear and when symptoms re-appear e.g. sickle cell anemia.

SAQ 2.3

Childhood is the period between infancy and puberty i.e. 0- 12 years. The term is non-specific and implies a varying range of years in human development. Children at different developmental stages react differently to illness and subsequently, hospitalization.

The emotional reactions of children also depend on the type and quantity of the stress and tension produced by the illness, hospitalization, misperception about hospitalization and medical procedure.

References

https://books.google.com.ng/books?id=NMCb5PeHXbcC&pg=PA28&lpg=PA28&dq=illness+behavior+in+adults&source=bl&ots=paggjkZWfH&

http://www.psychguides.com/guides/behavioral-disorder-symptoms-causes-and-effects/

http://psychology.about.com/od/psychosocialtheories/a/psychosocial_3.htm

Study Session 3: Medical Adherence

Introduction

Most students who sit for exams want to pass. Likewise most patients who visit hospitals need healing. Complete wellness might not be realizable if the patients do not adhere to their medication.

Medication adherence describes the degree to which a patient correctly follows medical guidance. This is achieved through different measures. In this study session you will understand the concept of medical adherence, assessing medication adherence, medication non-adherence, and nurses' role in medication adherence.

Learning Outcomes for study session 3

At the end of this study, you should be able to:

3.1 Discuss Medication Adherence
3.2 Explain ways of accessing medication adherence
3.3 Discuss Medication non-adherence
3.4 Highlight nurses' responsibility in ensuring adherence

3.1 Medication Adherence

Medication adherence describes the degree to which a patient correctly follows medical guidance. It can also refer to medication or drug compliance. This also includes medical device use, self-care, self-directed workouts, or treatment sessions.

The figure below shows drugs displayed to help you understand medication adherence

Figure: 1.1: *Drugs*

Source: *http://cdn.diabetesselfmanagement.com/2015/01/Phillips011415.jpg*

Medication adherence usually refers to whether patients take their medications as prescribed (e g, thrice daily), as well as whether they continue to take a prescribed medication. Medication adherence behavior can divided into 2 main concepts, namely, adherence and persistence.

Adherence refers to the intensity of drug use during the duration of therapy, whereas persistence refers to the overall duration of drug therapy.

Box 1.1: Definition of medication adherence
Medication adherence describes the degree to which a patient correctly follows medical guidance

3.2 Assessing Medication Adherence

Statistics has shown that rate of medication adherence drop after the first six months. Medication adherence is a growing concern to clinicians and other health stakeholders because of increasing evidence that non-adherence is predominant and related with severe outcomes and higher costs of care.

There are many different methods for assessing adherence to medications. They are:

- Direct method
- Indirect method

Direct method

This includes directly observed therapy, measurement of the level of medicine or metabolite in blood, and measurement of the biological marker in blood. Although these direct methods are considered to be detailed than indirect methods, there are also some limitations.

Some of such limitations may include patients pretense .There may be variations in metabolism that can affect serum levels. Direct methods are not practical for routine medical use.

Indirect Method

Indirect method involves the use of questionnaires, assessment of the patient's clinical response, electronic medication monitors, measurement of physiological markers, patient diaries, pharmacists refill, self-reports, pill counts, rate of prescription refills etc.

In-Text Question

Indirect method of assessing Medicare adherence include the following except

a. Pharmacist Refill b. Pill Counts c. Observed therapy d. Self-reports

In-Text Answer

c. Observed therapy

3.3 Medication non adherence

Non adherence to medications is common for patients with cardiovascular diseases. Non adherence could be as a result so many things. Some of which are:

1. Cost and duration of regimen could be a serious concern.
2. Perceived severity of the health problems
3. Difficulty in understanding therapy due to illiteracy, lack of necessary skills or language barriers.
4. Side effects or complications likely to arise from prescribed drug which could scare the patient.
5. Cultural or religious barriers of the patients. Some religious organizations do not permit their members to use drugs even when needed. It is considered a sin
6. Self-concept and value of the patients
7. Degree of confidence and satisfaction in the ability of the regimen in resolving the health problems.
8. Ready accessibility to and availability of the prescribed regimen.
9. Degree of inconvenience posed by the disease itself or the management.
10. Perception of significant others about the health problem and the effectiveness of the management regimen.

The issue of non-adherence is not based on the efforts of the patients alone. It involves all the stakeholders; patient, physicians, healthcare workers, healthcare facility and the patient's family. Non adherence could be tackled by taking some measures. Some of which are:

1. The creation of a patient-centered project

2. Encourage the patient's family to keep track of medication
3. Create an online medical database
4. Encourage patient participation and engagement
5. Creation of an application where patients can register
6. Promote meetings between medical staff and patients and their families
7. Changed and improved healthcare systems

The creation of a patient-centered project

This gives the patient information about their treatment, medication and especially their condition, and also provides an avenue by which patients can reach their physicians and vice-versa.

It gives room for the patients to ask questions about their treatment and the physician or healthcare workers to monitor the patient's treatment adherence. In developed countries, this can be done through a smartphone application. In poorer countries, a SMS system can be used and could be as effective.

Encourage the patient's family to keep track of medication

The patient's family could be encouraged to keep track of medication. This will reduce the stress of the patient. In case of scheduled appointment, systems should be put in place to encourage the family to follow up.

Create an online medical database

This is aimed at providing information to the patient about their disease and treatment. Putting this in place will aid adherence. The information provided must be easy to understand, so that the patient and their family can be properly informed about the condition without requiring specific medical knowledge.

Encourage patient participation and engagement

It is good for patients to work with their healthcare providers on preventive measures. They are less likely to develop health issues in the future if this is done. A smartphone-based or two-way SMS project could be used to encourage patient-doctor communication, in situations where the condition has been diagnosed.

Creation of an application where patients can register

The healthcare provider could create applications where patients can register and monitor their rate of adherence. These apps would reward the patient based on their adherence. Projects like this put the patient in control with support from the app, which could be designed by the provider. There could be pop-up reminders and data visualization on the application too.

Promote meetings between medical staff, patients and their families

Healthcare providers could organize meetings with Medical staff, patients and their families. In such meetings proper counseling and guidance could be made to help the patient adhere to his/her medication.

Changed and improved healthcare systems

The healthcare provider should give a continuous supportive environment to help the patients. For non-chronic diseases, post-treatment could be added so as to manage the condition of the patients and, in some cases, prevent a setback

In-Text Question

The culture and religious belief of patients could make them not to adhere to medication. True or false

In-Text Answer

True

3.4 Nurses' responsibilities in ensuring adherence

Nurses are stepping in to fill up the gap in cases where doctors are in short supply. Nurses plays very important roles in ensuring patients adhere to their medication.

Nurses have access to the patients than the physicians and therefore there is need for them to ensure that the patients adhere to their medication.

The picture below shows a nurse counseling some patients, a reflection of the role of nurse in medication adherence.

Figure 1.2: *A Nurse counselling some patients*

Source:*https://farm8.staticflickr.com/7250/7556646338_fc4ecc34f3_o.jpg*

Some of their responsibilities include:

- Emphasizing the value of the regimen
- Listening to your patient's concerns
- Accessing the patients literacy level
- Patient Advocate

Emphasizing the value of the regimen

There is need to tell the patients why they need to stick to the medication. Patients mention concerns of cost. You are expected to let them see beyond the cost and embrace the health benefits.

Listening to your patient's concerns

Nurses can notice concerns, such as cost or confusion about timing or dosage, and then aid the patient.

Accessing the patients literacy level

Health literacy refers to "accessing, understanding, and using information to make health decisions." Higher levels of health literacy are associated with higher levels of adherence. Low illiteracy level could lead to non- adherence to medication. Therefore there is need to access the patient's level of literacy.

Patient Advocate

It is the duty of the nurse to advocate for the patients; defending their rights. Patients are encouraged when they know you have their best interests at heart.

Activity 1.1 Nurses responsibility in ensuring medication adherence

Time Allowed: 15 Minutes

How will you ensure your patients adhere to their medications?

Summary

In study session 3, you have learnt that

1. Medication adherence is the degree to which a patient correctly follows medical guidance.
2. There are many different methods for assessing adherence to medications. They are:
   - Direct method
   - Indirect method
3. Direct method includes directly observed therapy, measurement of the level of medicine or metabolite in blood, and measurement of the biological marker in blood.
4. Indirect method involves the use of questionnaires, assessment of the patient's clinical response, electronic medication monitors, measurement of physiological markers, patient diaries, pharmacists refill, self-reports, pill counts, rate of prescription refills etc.
5. The reasons for non-adherence include the following:
   - Cost and duration of regimen could be a serious concern.
   - Perceived severity of the health problems

- Difficulty in understanding therapy due to illiteracy, lack of necessary skills or language barriers.
- Side effects or complications likely to arise from prescribed management could scare the patient.
- Cultural or religious barriers of the patients. Some religious organizations do not permit their members to use drugs even when needed. It is considered a sin

6. Non adherence could be tackled by taking some measures. Some of which are:
   - The creation of a patient-centered project
   - Encourage the patient's family to keep track of medication
   - Create an online medical database
   - Encourage patient participation and engagement
   - Creation of an application where patients can register
7. Some of the responsibilities of nurse in ensuring adherence include:
   - Emphasizing the value of the regimen
   - Listening to your patient's concerns
   - Accessing the patients literacy level
   - Patient Advocate

Self-Assessment Questions (SAQs) for Study Session 3

Now that you have completed this study session, you can assess how well you have achieved its Learning outcomes by answering the following questions.

Write your answers in your study Diary and discuss them with your Tutor at the next study Support Meeting.

You can check your answers with the Notes on the Self-Assessment questions at the end of this Module.

SAQ 3.1 (Testing Learning outcomes 3.1)
Define Medication adherence

SAQ 3.2 (Testing Learning outcomes 3.2)
State and explain the different methods for assessing adherence to medications

SAQ 3.3 (Testing Learning outcomes 3.3)
Mention ways of tackling non-adherence of medications

SAQ 3.4 (Testing Learning outcomes 3.4)
What is your role as a nurse in ensuring medication adherence?

Notes on SAQs for study session 3

SAQ 3.1

Medication adherence describes the degree to which a patient correctly follows medical guidance. It can also refer to medication or drug compliance. This also includes medical device use, self-care, self-directed workouts, or treatment sessions.

SAQ 3.2

There are many different methods for assessing adherence to medications. They are:

- Direct method
- Indirect method

Direct method

This includes directly observed therapy, measurement of the level of medicine or metabolite in blood, and measurement of the biological marker in blood. Although these direct methods are considered to be detailed than indirect methods, there are also some limitations.

Some of such limitations may include patients pretense .There may be variations in metabolism that can affect serum levels. Direct methods are not practical for routine medical use.

Indirect Method

Indirect method involves the use of questionnaires, assessment of the patient's clinical response, electronic medication monitors, measurement of physiological markers, patient diaries, pharmacists refill, self-reports, pill counts, rate of prescription refills etc.

SAQ 3.3

Non adherence could be tackled by taking some measures. Some of which are:

1. The creation of a patient-centered project
2. Encourage the patient's family to keep track of medication
3. Create an online medical database
4. Encourage patient participation and engagement
5. Creation of an application where patients can register
6. Promote meetings between medical staff and patients and their families
7. Changed and improved healthcare systems

SAQ 3.4 Some of their responsibilities include:

- Emphasizing the value of the regimen
- Listening to your patient's concerns
- Accessing the patients literacy level
- Patient Advocate

Emphasizing the value of the regimen

There is need to tell the patients why they need to stick to the medication. Patients mention concerns of cost. You are expected to let them see beyond the cost and embrace the health benefits.

Listening to your patient's concerns

Nurses can notice concerns, such as cost or confusion about timing or dosage, and then aid the patient.

Accessing the patients literacy level

Health literacy refers to "accessing, understanding, and using information to make health decisions." Higher levels of health literacy are associated with higher levels of adherence. Low illiteracy level could lead to non- adherence to medication. Therefore there is need to access the patient's level of literacy.

Patient Advocate

It is the duty of the nurse to advocate for the patients; defending their rights. Patients are encouraged when they know you have their best interests at heart.

References

Cockerham, W. C. (2003). Medical Sociology. (9th edition). NY: Prentice Hall.

Santrock J. (2008). Life- Span development (11th Edition). McGraw Hill Publishing House.

Potter and Perry (2010). Fundamentals of Nursing: Concepts, Process and Practice (4th Edition). Mosby Publishing Company.

Christenesen B and Kockrow E (2004). Foundations of Nursing (4th Edition). Mosby Publishing Company.

Barbara Kozier and Glenora Erb (2006). Fundamentals of Nursing (8th Edition). Addison-Wesley Publishing Company.

http://medical-dictionary.thefreedictionary.com/illness

http://dictionary.reference.com/browse/disease

http://www.livestrong.com/article/82411-major-types-diseases/

http://nursingcrib.com/nursing-notes-reviewer/stages-of-illness-behavior/

http://circ.ahajournals.org/content/119/23/3028.full

https://novoed.com/mhealth/reports/50424

http://study.com/academy/lesson/roles-and-functions-of-the-nurse.html

Study Session 4: Illness Cognition

Introduction

Health they say is wealth. The desire to live healthy is one of the goals of the average man. However the wellbeing of man is threatened by illness. Most patients are mainly familiar with common sense knowledge of illness called cognition. It has become important to learn about illness.

In this study session you will learn about illness cognition, illness and health, the concept of disease causation, models of disease causation and patterns of illness.

Learning Outcomes for study session 4

At the end of this study, you should be able to:

4.1 Define illness and health
4.2 Explain illness cognition
4.3 Discuss the concept of disease causation
4.4 Discuss the models of disease causation
4.5 Explain the patterns of illness

4.1 Illness and healthiness

Individuals and communities have their own concept of health and illness. This concept guide their health related behaviors; irrespective of color, ethnicity or religious association. Lau (1995) asked a group of young healthy volunteers to define what being healthy means, their responses includes being physically **healthy**, ability to maintain a good psychological well-being, absence of **illness**/symptoms to mention a few.

The World Health Assembly in 1974 coined a universally acceptable definition of **health** as a state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity' (WHO, 1974).

The term **'Illness'** also has several definitions ranging from not feeling normal/right, presence of physical/psychological symptoms, having a specific illness to standard definitions like 'Individual's perception and labeling of a set of physical and emotional

experience' (Cocker ham, 2003) which highlights the role of cognition on illness perception.

In-Text Question

----------is the individual's perception and labeling of a set of physical and emotional experience which highlights the role of cognition on illness and perception.

In-Text Answer

Illness

4.2 Illness Cognition

The term **cognition** is from a Latin word cognoscere meaning "to know". It can be described in a wider sense to mean the act of knowing or knowledge, and may be interpreted in a social or cultural sense to describe the emergent development of knowledge and concepts within a group that results in both thought and action.

Illness Cognition is defined as a patient's common sense beliefs about their illness. (Leventhal & Nerenz, 1985) and it is possible to measure these beliefs. Illness cognitions and health beliefs relate both directly and indirectly to recovery and can play a vital role in a patient's progress.

Box 1.1: Definition of Illness Cognition
Illness Cognition is defined as a patient's common sense beliefs about their illnesses

The effect reveals that a patient's illness beliefs will affect their subsequent behavior in dealing with the disease. These beliefs can have a negative or positive influence on their progress depending on the nature of these beliefs and the illness itself.

Leventhal attempted to list the factors that make up an individual's illness perceptions and they are in five dimensions. They are:

- Identity
- Perceived cause of illness
- Time line
- Consequences
- Cure & control

1. **Identity**: This is the label a patient gives his condition in terms of diagnosis (e.g. Cold) and symptoms (e.g. runny nose, fever)
2 **Perceived cause of illness**: These are the factors causing or contributing to the illness as believed by the patient. These causes may be biological (for example, a virus or a lesion) or psychosocial (e.g. stress, unhealthy lifestyle)

3 **Time line**: This refers to a patient's beliefs about how long the illness will last, it is either acute (short term) or chronic (a disorder that persists for a long time and is either incurable or results in pathological changes that limit normal functioning).

3. **Consequences:** This refers to the patient's perceptions of the possible effects of the illness on their life. Such consequences can be physical (pain, mobility problems) emotional (lack of social contact, anxiety) and others such as time off work and/or disfigurement.
4. **Cure & control:** Patients also believe that the illness can be treated and cured and the extent to which the outcome of their illness is controlled is either by themselves or by powerful others e.g. by taking medication or getting adequate of rest.

In-Text Question

……. refers to a patient's beliefs about how long the illness will last

In-Text Answer

Timeline

4.3 Concept of disease causation

There are several concepts regarding disease causation. They are:

- Germ theory of disease
- Epidemiological triad
- Multifactorial Causation
- Web of causation

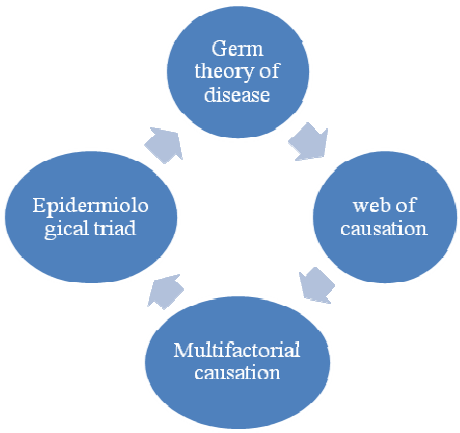


Figure 1.1*Concept of disease causation*

Germ theory of disease

It states the one to one relationship between causal agent and disease. Louis Pasteur (French bacteriologist) proposed this theory and later adjusted by Robert Koch. In respect to this theory, the singular cause of disease is microbes.

Epidemiological triad

Epidemiological triad reveals that disease is caused by interactions between agent, host and environment. Agent is an organism/substance which may cause the disease to continue e.g. organisms, chemicals, radiation, etc.

Similarly host is defined as man or an animal that gives existence to infections agents in the environment. Host factors are: age, sex, ethnicity, genetic factors, etc.

Multifactorial Causation

Multifactorial causation do not put emphasis on the concept of the disease "agent" but rather talk about array of interactions between the host and environment (agent is included under the environment). It describes the factors liable for causation of chronic non-infectious disease like cancer, heart disease.

Web of causation

It is meant for chronic disease where disease agent is not known and it is the outcome of interaction of multiple factors e.g. Myocardial infection.

In-Text Question

----------states the one to one relationship between causal agent and disease.

In-Text Answer

Germ theory of disease

4.4 Models of disease causation

There are different models of disease causation. They are:

- The Biological Model of disease causation
- The Bio psychosocial Model

The Biological Model of disease causation

The biomedical model, which dominates medicine, is a reductionist, single-factor model of illness that regards the mind and the body as separate entities and emphasizes illness concerns over health.

The Figure below illustrates the interaction of biological factors and illness causation. This interaction formed the basis of the biological model.

Figure 1.1 *Formation of the biological model*

The Bio psychosocial Model

The bio psychosocial model fundamental assumption is that health and illness are consequences of the interplay of biological, psychological, and social factors (Suls & Rothman, 2004). The bio psychosocial model maintains that health and illness are caused by multiple factors and produce multiple effects.

The model further explains that the mind and body cannot be distinguished in matters of health and illness because both so clearly influence an individual's state of health. The bio psychosocial model emphasizes health and illness rather than regarding illness as a deviation from some steady state.

The model maintains that the process of diagnosis should always consider the interacting role of biological, psychological, and social factors in assessing an individual's health or illness. Therefore, an interdisciplinary team approach may be the best way to make a diagnosis.

Recommendations for treatment must also involve all three sets of factors. By doing this, it should be possible to target therapy uniquely to a particular individual, consider a person's health status in total, and make treatment recommendations that can deal with more than one problem simultaneously.

Box 1.2: The bio psychosocial model assumption

The bio psychosocial model fundamental assumption is that health and illness are consequences of the interplay of biological, psychological, and social factors

The health professional must understand the social and psychological factors that contribute to an illness in order to treat it appropriately.

The figure below illustrates the interaction of biological, social and psychological factors on our health and wellbeing. This interaction formed the basis of the bio psychosocial model of health.

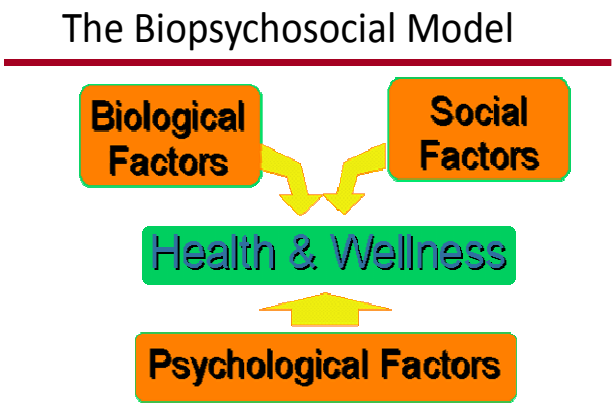


***Figure 1.2**: The bio psychosocial model*

4.5 Patterns of Illness

Illness could exist in these patterns:

- Acute
- Chronic

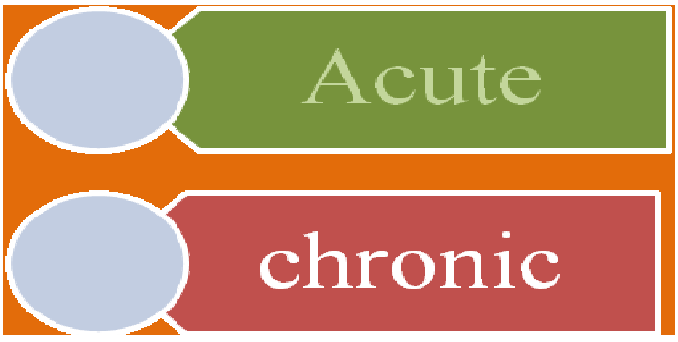


***Figure 1.3**: Patterns of illness*

Acute illness is a self-limiting disease which is mostly characterized by the symptoms having a rapid onset. These symptoms are fairly intense and resolve in short period of time as either cure or death in the patient. The common examples are cold and flu, malaria, headaches etc.

Chronic illness are those that occur across the whole range of illness, complex in how they are caused, are often long-lasting and persistent in their effects and can produce a range of complications. Examples are hypertension, diabetes, cancer, HIV etc.

Differences between acute and chronic illness

Table 1.1: Differences between acute and chronic illness

	Acute	**Chronic**
Onset	abrupt	usually graduated
Duration	limited	lengthy, indefinite
Cause	single	multiple, changes
Diagnosis	usually accurate	often uncertain
Prognosis	usually accurate	often uncertain
Intervention	usually effective	often indecisive
Outcome	Cure	no cure
Uncertainty	Minimal	Pervasive

Summary

In study session 4, you have learnt that:

1. Illness is the individual's perception and labeling of a set of physical and emotional experience
2. Healthiness is the ability to maintain a good psychological well-being, absence of illness/symptoms
3. Illness Cognition is defined as a patient's common sense beliefs about their illness.
4. Illness perceptions are in five dimensions. They are:
   - Identity
   - Perceived cause of illness
   - Time line
   - Consequences
   - Cure & control

5. Identity is the label a patient gives his condition in terms of diagnosis.

6. Time line refers to a patient's beliefs about how long the illness will last
7. Consequences refer to the patient's perceptions of the possible effects of illness on their life.
8. There are several concepts regarding disease causation. Some of which are:
   - Germ theory of disease
   - Epidemiological triad
   - Multifactorial Causation
   - Web of causation

9. Germ theory of disease states the one to one relationship between causal agent and disease.
10. Epidemiological triad reveals that disease is caused by interactions between agent, host and environment
11. Multifactorial causation do not put emphasis on the concept of the disease "agent" but rather talk about array of interactions between the host and environment
12. There are different models of disease causation. They are:
    - The Biological Model of disease causation
    - The Bio psychosocial Model
    - Illness could exist in Acute and Chronic patterns
13. Acute illness is a self-limiting disease which is mostly characterized by the symptoms having a rapid onset.
14. Chronic illness can produce a range of complications.

Self-Assessment Questions (SAQs) for Study Session 4

Now that you have completed this study session, you can assess how well you have achieved its Learning outcomes by answering the following questions.

Write your answers in your study Diary and discuss them with your Tutor at the next study Support Meeting.

You can check your answers with the Notes on the Self-Assessment questions at the end of this Module.

SAQ 4.1 (Testing Learning outcomes 4.1)

Define illness and healthiness

SAQ 4.2 (Testing Learning outcomes 4.2)

Explain illness cognition and state the illness perception dimensions according to Leventhal.

SAQ 4.3 (Testing Learning outcomes 4.3)

Discuss the concept of disease causation using the Epidemiological triad.

SAQ 4.4 (Testing Learning outcomes 4.4)

Discuss the Biological Model of disease causation

SAQ 4.5 (Testing Learning outcomes 4.5)
Highlight the differences between acute and chronic illness

Notes on SAQs for study session 4

SAQ 4.1

Healthiness is ability to maintain a good psychological well-being or the absence of illness/symptoms.

Illness is the individual's perception and labeling of a set of physical and emotional experience

SAQ 4.2

Illness Cognition is defined as a patient's common sense beliefs about their illness.

The term **cognition** is from a Latin word cognoscere meaning "to know". It can be described in a wider sense to mean the act of knowing or knowledge, and may be interpreted in a social or cultural sense to describe the emergent development of knowledge and concepts within a group that results in both thought and action.

Illness perceptions dimensions are the following:

- Perceived cause of illness
- Time line
- Consequences
- Cure & control

SAQ 4.3

Epidemiological triad reveals that disease is caused by interactions between agent, host and environment. Agent is an organism/substance which may cause the disease to continue e.g. organisms, chemicals, radiation, etc.

Similarly host is defined as man or an animal that gives existence to infections agents in the environment. Host factors are: age, sex, ethnicity, genetic factors, etc.

SAQ 4.4

The Biological Model of disease causation is a reductionist, single-factor model of illness that regards the mind and the body as separate entities and emphasizes illness concerns over health.

SAQ 4.5

The differences between acute and chronic illness are discussed below.

	Acute	**Chronic**
Onset	abrupt	usually graduated
Duration	limited	lengthy, indefinite
Cause	single	multiple, changes
Diagnosis	usually accurate	often uncertain
Prognosis	usually accurate	often uncertain
Intervention	usually effective	often indecisive
Outcome	cure	no cure
Uncertainty	minimal	pervasive

References

Cockerham, W. C. (2003). Medical Sociology. (9th edition). NY: Prentice Hall.

Glanz, K., Rimer, B.K., & Lewis, F.M. (2002). Health behavior and health education: Theory, research, and practice. San Francisco: Wiley & Sons.

Kinzbrunner, B.M., Weinreb, N.J. & Policzer, J.S. (2002) Common Problems: End of Life Care. McGraw-Hill.

Okun, B. & Nowinski, J.(2011) Saying Goodbye Berkley Publishing Group, Harvard University.

Weiss, L. G. and Lonnquist, L. E. (2005). The Sociology of Health, Healing and Illness, fifth edition, Safari book online. http//www.safarix.com/.Accessed April, 2014.

http://humandiseases-nishchhal.blogspot.com/2010/02/concept-of-disease-causation.html

Study Session 5: Coping models with adaptation to illness

Introduction

Change is inevitable and it occurs in our day to day activity. At times, we need to manage these changes. The process of dealing with these day to day changes is known as Coping.

Humans are influenced by their internal and external environment, and in turn man has tried to exert his own influence on the environment.

Coping is concerned with day to day changes in our body while interacting with the environment.

In this study session you will learn about coping, coping models in the context of adaptation to illness, responses to stress model, motivational model of coping and the community stress prevention model.

Learning outcomes for study session 5

At the end of this study, you should be able to:

5.1 Define Coping
5.2 Discuss the coping models in the context of adaptation to illness
5.3 Explain the responses to stress model
5.4 Discuss the motivational model of coping
5.5 Explain the Community Stress Prevention Model

5.1 Coping

According to Folkman & Lazarus (1984) **Coping** can be described as constantly changing cognitive and behavioral efforts to manage specific external and internal demands that are appraised as tasking or exceeding the resources of a person.

Managing stress includes accepting, tolerating, avoiding, or minimizing the stressor as well as mastery over the environment. **Coping**, then, is all purposeful attempts to manage stress regardless of effectiveness.

The second definition is offered by the Red Cross as anything people do to adjust to the challenges and demands of stress. It is any adjustments made to reduce the negative impact of stress.

Box 1.1 Definition of coping

Coping is anything people do to adjust to the challenges and demands of stress.

5.2 Coping model in the context of adaptation to illness

Coping model in the context of adaptation to illness could be expressed using several models. Some of which are:

- The Transactional Model of Stress and Coping
- Responses to stress Model
- Motivational Model of Coping
- The Community Stress Prevention Model

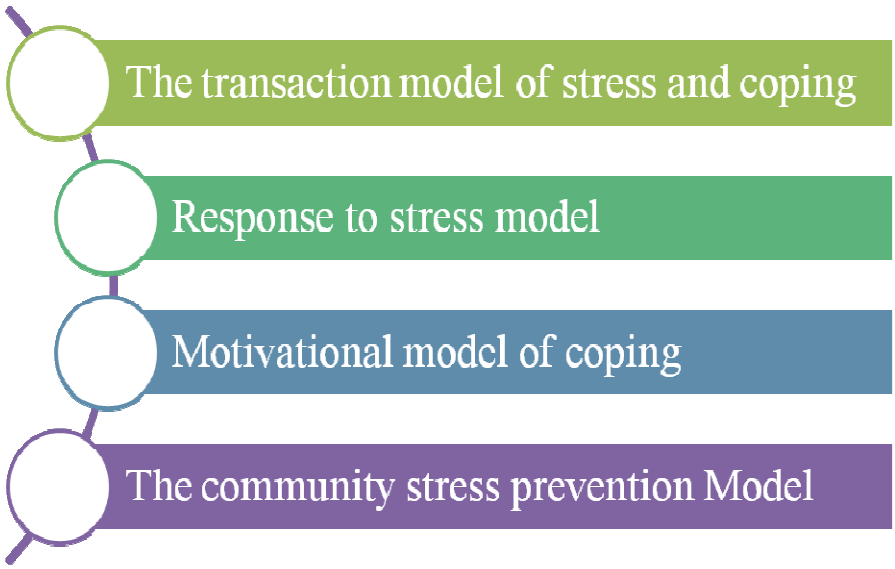


Figure 1.1 *The coping models*

5.2.1 The transactional model of stress and coping

The transactional model of stress and coping is a systems-based framework for understanding and evaluating the processes of coping with stressful events. Most widely used model, Folkman and Lazarus (1984) first presented this model of stress and coping in the early 1980's.

The key factors in the adaptation to chronic illness are disease-specific coping efforts, changes in illness representation over time, interaction between psychological reality of disease and effective response, procedures for coping with the disease and interaction with context with stress.

Let's review the core assumptions of this model.

Assumptions

1. Stressful experiences are conceptualized as person-environment transactions.
2. These transactions are dependent on the impact of the external stressor. So, this impact is facilitated first by the individual and environmental antecedents, which interact in the appraisal of the stressor and leads to an individual core relational themes for each emotion.

This mediate coping response then contributes to revisions in relational narrative that ultimately result in emotions, functioning, and health outcomes.

3. Impact is the reconciled individual/environmental past which is a result of the person's repeated appraisal of the stressor, and coping responses.
4. Adaptation is based on the entire system changing from moment to moment, from one emotional context to another. Changes can be the result of one antecedent variable, mediating process, or outcome.

According to the Transactional Model of Coping, the transactional model concepts are:

- Primary Appraisal
- Secondary appraisal

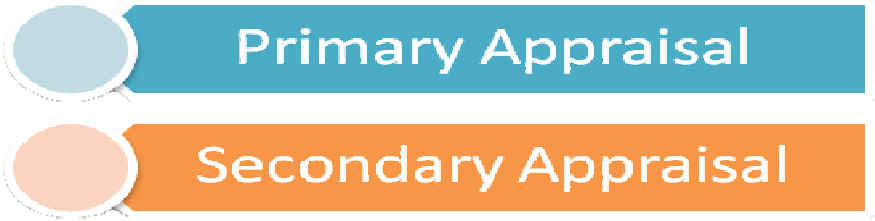


Figure1.2: *Traditional Model concepts format*

Primary Appraisal: It is the determination of the significance of the event whether it is stressful, positive, controllable, challenging, or irrelevant. When a person is confronted with a stressor they evaluate the potential threat.

Secondary appraisal: It is made to assess the controllability of the stressor and a person's coping resources and options. This determines what the person can do about the situation.

Terms

Coping efforts*:* They are strategies aimed at regulation of the problem and lead to coping outcomes.

Problem management: Strategies directed at changing a stressful situation.

Emotional regulation: Strategies aimed at changing the way a person thinks or feels about a stressful situation.

Meaning-based coping: Coping processes that induce positive emotion, which then sustains the coping process by allowing re-enactment of problem- or emotion-focused coping.

Outcomes of coping: Emotional well-being, functional status, health behaviors.

Dispositional coping styles: Generalized ways of behaving that can affect a person's emotional or functional reaction to a stressor; seen as relatively stable across time and situations.

Optimism: Tendency to have generalized positive expectancies for outcomes.

Information seeking: Efforts to obtain information in order to assist meaning making process.

Meaning-based coping: Coping processes that induce positive emotion, which then sustains the coping process by allowing re-enactment of problem- or emotion-focused coping.

Outcomes of coping: They include Emotional well-being, functional status and health behaviors.

Dispositional coping styles: Generalized ways of behaving that can affect a person's emotional or functional reaction to a stressor; seen as relatively stable across time and situations.

Optimism: Tendency to have generalized positive expectancies for outcomes.

Information seeking: Efforts to obtain information in order to assist meaning making process.

Emotion-focused coping: It is coined by Folkman & Lazarus (1984). It generally refers to coping efforts directed inward in order to strengthen the emotional response to the stressor.

This type of coping is further delineated by denial or avoidance, distraction or minimization, wishful thinking, self-control of feelings, seeking meaning, self-blame, and expressing or sharing feelings.

Problem-focused coping: It relates to coping efforts directed outward as a means to change the environment. They are efforts that act on the source of stress to change the person, the environment, or the relationship between planned problem solving and confrontation.

In-Text Question

One of the assumptions of the transactional model is that stressful experiences are conceptualized as person-environment transactions. True or False

In-Text Answer

True

5.3 Responses to stress Model

This developmental and contextual theoretical framework emphasizes the importance of developmental changes in the nature of stress experienced by children and adolescents, the internal /external constraints that limit coping processes, and the complex interplay between voluntary and involuntary responses to stress.

Compass (an author) and colleagues theorize that the proportion of voluntary and involuntary responses will change through development with an increase in coping repertoire expanding during childhood and adolescence.

As individuals develop, coping shifts from use of simple behavioral responses implemented with external support to use of complex strategies aimed at altering internal states and used independently.

It emphasizes developmental changes in nature of stress, internal/external constraints limiting coping processes, and a complex interplay between voluntary and involuntary response to stress.

It assumes that:

- Involuntary responses reflect individual differences in temperament, over-learned and automatic responses
- An increase in secondary control coping and emotion-focused coping decreases in disengagement with maturity.

This model expands on the transactional model by considering involuntary responses to stress. It includes five factors and can divide into voluntary and involuntary strategies.

Voluntary Strategies

1. **Primary Control Coping:** Attempts to modify stressful problem or emotion (problem solving)
2. **Secondary Control Coping**: Attempts to adapt via cognition (cognitive restructuring)
3. **Disengagement Coping**: Attempts to redirect attention away from the stressor or emotional reaction (denial, wishful thinking) Wadsworth et al, 2004

Involuntary Strategies

Involuntary strategies involve:

- Involuntary Engagement
- Involuntary Disengagement

Involuntary Engagement includes responses that orient the individual toward the stressful circumstance or their emotional reactions. These include emotional and physical arousal, rumination, intrusive thoughts, and impulsive action.

Involuntary Disengagement includes responses that orient the individual away from the stressful circumstance or their emotional reactions. These include cognitive interference, escape, emotional numbing, and inaction. Wadsworth et al (2004), p. 144

In-Text Question

Responses stress model emphasizes the importance of developmental changes in the nature of stress experienced by children and adolescents and the internal /external constraints that limit coping processes. True or False

In-Text Answer

True

5.4 Motivational Model of Coping

The Motivational Model of Coping described by Skinner and Wellborn (1997) is a life span theory based on the assumption that all people have basic needs for understanding, for competence, and for autonomy or self-determination.

It suggests three universal stressors:

- Neglect(because it threatens understanding)
- Chaos(because it undermines competence)
- Coercion (because it encroaches on independence).

Three self-system processes provide psychological resources for coping. They correspond to secure internal working models, perceived control, and autonomy orientations.

The motivational model assumes that children actively construct beliefs or internal representations of themselves, the social context, and interactions between the two.

These beliefs are based on previous experiences in the world. Children's self-efficacy may be challenged by chaotic social contexts. Self-efficacy beliefs lead to interpretations of competence. Self-system processes become either source of distress or resource in event of trauma.

Competence, Chaos, and Control

Children's sense of competence may be challenged by social contexts characterized as chaotic. Examples include undefined expectations, inconsistent rules/unexplained rules, being pushed to do activities beyond their capacity, not have opportunities for practice and lack of guidance.

Children's beliefs about their capacity to enact effective strategies and the responsiveness of the environment (chaos) translate to interpretations of failures as evidence of incompetence.

Children with low perceived control are more likely to generalize this sense of incompetence and react to even mild difficulties with confusion and panic. Children with a perception of high control seem more able to focus on overcoming obstacles with goal-directed action.

Autonomy or self-determination

Children need to experience themselves as free to choose goals and action. Coercion refers to children being pressured to behave in certain ways or to express certain feelings, or a lack of support for autonomy. Children with a low sense of autonomy tend to blame themselves and have difficulty regulating their behavior.

Relatedness, Neglect, and Internal Working Models

Neglect is characterized as social interactions that undermine a child's need for relatedness (understanding). Neglect leads to insecure working models which lead to children doubting their own value, viewing others as likely to be dangerous, and reacting to stressful events with anxiety and expectations of negative consequences.

Self as a Source of Distress or Intrapersonal Resource

These self-system processes then become either a source of distress or a resource in the event of trauma.

In-Text Question

Neglect leads to insecure working models which lead to children doubting their own value, viewing others as likely to be dangerous, and reacting to stressful events with anxiety and expectations of negative consequences. True or False

In-Text Answer

True

5.5 The Community Stress Prevention Model

The Community Stress Prevention Model emphasizes resilience and is thought to be appropriate for both prevention and intervention following disaster or illness. The model identified six dimensions related to coping with adversity. The model suggests that by using these six dimensions, coping styles can be effectively identified in individuals and communities.

The six dimensions central to coping with adversity are:

1. Beliefs/Values
2. Affection
3. Social
4. Imagination
5. Cognitive
6. Physiological

Beliefs/Values:

It relies on values to cope. A child turns to their belief system and relies upon their basic values as a means of coping.

Affection

This is the emotional expression of coping mechanism. Children utilize their capacity to express their emotions as a coping mechanism. They need opportunities to share their anxiety, fear, anger, grief and be validated by significant others in their lives.

Social

It implies Seeking support/relationships. Children cope with adversity through social channels by seeking support and control through relationships. The roles and responsibilities assigned, based upon the social/cultural, context (e.g., classroom, family) can either increase or decrease connection. This will impact emotional security and well-being.

Imagination

It is the creative expression to cope. Children frequently utilize their creativity as a means of coping with trauma. Example: The pre-school children will recreate their traumatic experience using toys, art supplies, etc. Imaginative processing allows children to experience mastery over the traumatic experience.

Cognitive

It is the need for honest dialogue & guidance. Children who make cognitive efforts to cope with trauma exposure can benefit from age-appropriate honest dialogue regarding the event(s) and suggestions for addressing a range of difficulties.

Physiological

It is concerned with using Physical activity as coping. Physical activity has been found to be a positive coping strategy. Games/exercise and other forms of physical activity provides a buffer of time that supports informal processing of the traumatic experiences. Lahad, Shacham, & Niv, 2000

Activity 1.1

Time Allowed: 10 Minutes

Discuss children's coping mechanisms

Summary

In study session 5, you have learnt that:

1. Coping is the constantly changing cognitive and behavioral efforts to manage specific external and internal demands that are appraised as tasking or exceeding the resources of a person
2. Coping model in the context of adaptation to illness could be expressed using several models. Some of which are:
   - The Transactional Model of Stress and Coping
   - Responses to stress Model
   - Motivational Model of Coping
   - The Community Stress Prevention Model

3. The transactional model of stress and coping is a systems-based framework for understanding and evaluating the processes of coping with stressful events
4. One of the assumptions of the transactional model of stress and coping is that adaptation is based on the entire system changing from moment to moment, from one emotional context to another.

5. Responses to stress Model emphasizes the importance of developmental changes in the nature of stress experienced by children and adolescents, the internal /external constraints that limit coping processes, and the complex interplay between voluntary and involuntary responses to stress.
6. The Motivational Model of Coping is a life span theory based on the assumption that all people have basic needs for relatedness to others, for competence, and for autonomy or self-determination.
7. The Community Stress Prevention Model emphasizes resilience and is thought to be appropriate for both prevention and intervention following disaster or illness.

Self-Assessment Questions (SAQs) for Study Session 5

Now that you have completed this study session, you can assess how well you have achieved its Learning outcomes by answering the following questions.

Write your answers in your study Diary and discuss them with your Tutor at the next study Support Meeting.

You can check your answers with the Notes on the Self-Assessment questions at the end of this Module.

SAQ 5.1 (Testing Learning outcomes 5.1)

According to the Red Cross definition, what do we mean by coping?

SAQ 5.2 (Testing Learning outcomes 5.2)

Explain the Coping model in the context of adaptation to illness using the transactional model of stress and coping

SAQ 5.3 (Testing Learning outcomes 5.3)

Discuss the responses to stress model and explain the Primary Control, Secondary Control and disengagement Coping.

SAQ 5.4 (Testing Learning outcomes 5.4)

Mention the three universal stressors

SAQ 5.5 (Testing Learning outcomes 5.5)

The Community Stress Prevention Model suggests that by using some dimensions, coping styles can be effectively identified in individuals and communities. Highlight the dimensions.

Notes on SAQs for study session 5

SAQ 5.1

According to the Red Cross definition, coping is anything people do to adjust to the challenges and demands of stress. It is any adjustments made to reduce the negative impact of stress.

SAQ 5.2

The transactional model of stress and coping is a systems-based framework for understanding and evaluating the processes of coping with stressful events.

Some of the assumptions for this model include:

- Stressful experiences are conceptualized as person-environment transactions.
- Adaptation is based on the entire system changing from moment to moment, from one emotional context to another.

SAQ 5.3

Responses to stress model emphasizes the importance of developmental changes in the nature of stress experienced by children and adolescents, the internal /external constraints that limit coping processes, and the complex interplay between voluntary and involuntary responses to stress.

- **Primary Control Coping:** Attempts to modify stressful problem or emotion (problem
- **Secondary Control Coping**: Attempts to adapt via cognition (cognitive restructuring)
- **Disengagement Coping:** Attempts to redirect attention away from the stressor or emotional reaction (denial, wishful thinking) Wadsworth et al, 2004

SAQ 5.4

- Neglect(because it threatens relatedness)
- Chaos(because it undermines competence)
- Coercion (because it impinges on autonomy).

SAQ 5.5

The six dimensions central to coping with adversity are:

1. Beliefs/Values
2. Affection
3. Social
4. Imagination
5. Cognitive
6. Physiological

References

Cockerham, W. C. (2003). Medical Sociology. (9th edition). NY: Prentice Hall.

Glanz, K., Rimer, B.K., & Lewis, F.M. (2002). Health behavior and health education: Theory, research, and practice. San Francisco: Wiley & Sons.

Kinzbrunner, B.M., Weinreb, N.J. & Policzer, J.S. (2002) Common Problems: End of Life Care. McGraw-Hill

Okun, B. & Nowinski, J.(2011) Saying Goodbye Berkley Publishing Group, Harvard University.

Weiss, L. G. and Lonnquist, L. E. (2005). The Sociology of Health, Healing and Illness, fifth edition, Safari book online. http//www.safarix.com/.Accessed April, 2014.

Study Session 6: Coping response

Introduction

The state of being ill is a threat for human existence. There are several approaches and responses that man gives as a result of these illnesses. All these purposeful interactions aimed at managing stress/illness are known as coping.

In this study therefore you will learn about coping response, stages of responses in illness, coping with a diagnosis, coping and culture.

Learning Outcomes for study session 6

At the end of this study, you should be able to:

6.1 Explain coping response
6.2 Highlight the Stage of Responses in illness
6.3 Discuss coping with a diagnosis
6.4 Explain coping and culture

6.1 Coping responses

Freud (a psychotherapist) first talked about the unconscious mechanisms of coping. His discussion of defense mechanisms, such as denial, repression, rationalization, and projection, were unconscious ways in which individuals managed stress and anxiety. By the 1970s, the research moved into examining conscious coping strategies.

Lazarus (a psychologist) was one of the first to develop a theoretical perspective about coping as a conscious process. He first defined stress as consisting of three components:

- Primary appraisal, the process of perceiving the stress as a threat to oneself;
- Secondary appraisal, the process whereby one brings to mind the potential response to the threat;
- **Coping**, which is the process of carrying out the response(s) to deal with the stress?

We can conceptualize coping strategies in multiple ways. They are:

- Biological/physiological Coping
- The cognitive component of coping
- The learned component of coping
- Intention

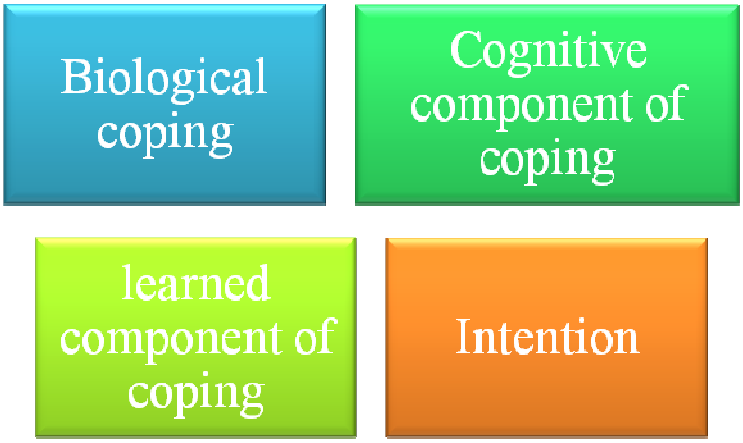


Figure 1.2 *Coping strategies*

Biological/physiological Coping

The body has a natural method of coping with stress. Any threat or challenge perceived by an individual in the environment triggers a physiological chain of events. The sympathetic/adrenal system secretes epinephrine and nor epinephrine. This is the "fight or flight" response.

The cognitive component of coping

The cognitive component of coping refers to the mental process and how the individual thinks about the situation. How they think about it then leads to behavior. We'll talk more about this aspect when we discuss the transactional model of coping.

The learned component of coping

It refers to strategies learned from modeling/observation. It includes everything from social learning theories, which assume that much of human motivation and behavior is the result of learning. This includes cultural preferences for coping.

Intention

Intentionality refers to whether the strategy is voluntary or involuntary; thoughtful and intentional or automatic.

In-Text Question

Coping strategies can be conceptualized into the following ways except

a. Biological/physiological Coping
b. The cognitive component of coping
c. The trashing coping
d. Intention

In-Text Answer

The trashing coping

6.2 Stages of responses in illness

There are different stages of responses in illness .They are:

1. Crisis
2. Isolation
3. Anger
4. Reconstruction
5. Intermittent Depression
6. Renewal

Crisis

In the crisis stage, the patient is seriously ill and very frightened. There is decrease in his ability to respond to others psychologically and physically. The sick directs his energies toward healing, and controlling panic. The patient is often too sick to even be frightened.

Events are often confused. Time is distorted. Disorientation is common. At these times we fall back on our innate biological ability to heal. The support network is highly stressed. There is increase in anxiety, especially if the support network must carry the full responsibilities of arranging for medical care and handling finances.

The family anxiety can be energizing. The family may feel a need, sometimes an obligation, to be highly supportive of the patient. During the crisis stage almost all of the patient's energy and attention are focused on responding to the physical onslaught of the illness. Surviving is the primary concern.

Isolation

Over time, the acute nature of the illness may decrease. But total recovery does not occur, and the illness persists. There is a dawning awareness of everyone's part that the situation has become a chronic one and that there will be no full recovery.

There is so much uncertainty about the future that the patient may not be able to sleep at night and may seem restless and distracted during the day. The lack of an expectable future constitutes a major assault on the patient’s self-image. There is a belief that no one can understand the devastation of the losses.

The family often exhausted itself during the acute crisis stage. Family members may become aware that they are angry, fearful, and disgusted about the whole situation. Friends also tend to call it quit at this point. The idea of chronic illness is really terrifying to most people. After an initial burst of energy, some friends may find it too overwhelming. Contact with the patients and family could reduce at this junction.

Some patients have been devastated by an apparent lack of concern shown by people for whom they care. During the isolation stage, patients look inward and experience many negative feelings about themselves. In the isolation stage open communications are vital. Talking about feelings is very important. Communication and sharing are ways to break the isolation.

Anger

The sick person suffers from severe upset, terror, anxiety, and helplessness. The commonly experienced feelings of despair may result in contemplation of suicide. There are two reasons why the patient targets himself or herself for these feelings of anger and despair.

In order to provide some meaning for what has happened, many people irrationally conclude they have bought disease on themselves by being faulty or wicked in some way.

Another reason for suicidal thoughts is that illness breeds a sense of helplessness. The chronic disease cannot be wished away. The disabilities are there to struggle with every day, and the threat of a major recurrence or increase in symptoms may be a constant anxiety tucked away not far from consciousness.

With the feeling that the underlying problem cannot be solved and the belief that it is the patient's fault, many patients suffer intense unhappiness.

Another serious problem of the anger stage is the strain on the family. Families who fare better during this stage understand that the sick person is not the same entity as the disease; they see that the whole family is in this predicament together and are committed to coming out of it as soon as possible.

Family members need to devise ways to nurture and adequately support each other in order to cope with both the anxiety and the practical life changes accompanying chronic illness.

Fear and anger are disruptive emotions caused by a sense of loss of control. Patients, family, friends, and helpers should all focus on the strength that is left and on the accomplishments that can still be achieved. This basic rule is a key to dealing with anger.

Reconstruction

The sick person may now be feeling much stronger physically or may have enough time to master new living skills. The sick person is learning the possibilities and limits of the new competencies.

Friends are selected on how well they react to the fact of illness. The family establishes new routines .It is a reconstruction of the sense of oneself as a cohesive, intact entity. The

reconstruction takes on many concrete aspects, such as the development of new skills, but the most important value is emotional.

Intermittent depression

The joy associated with new skills can give way to new feelings of despair as the patient recalls how much simpler it was to do routine things the old, easy way. Nostalgia and grief may combine to produce sadness and discouragement.

Intermittent depressions seem to combine two feelings. One is the awareness of loss of function that occurs several times a day in the course of ordinary living. There is a second element involved. If the awareness of loss arouses a distinct image of what life would be like if the illness did not occur. This image is called the **phantom psyche**.

The phantom psyche is usually not far from consciousness. It is the self-punishing mechanism whereby the chronically ill person continually erodes his or her own self-worth and competence.

Renewal

The losses, and the sadness they cause, never go away entirely. There is a sense of lingering regret for all the capacities that have been lost. A person who has mastered the technique of using a wheelchair can feel very proud of this achievement and know full well that this device is essential for retaining an active life. But the person does not have to like it but make expectations realistic**.**

A second essential skill is an active approach to problems. It consists of defining the problem and determining the outcome you want. It involves trying to ensure that any energy expended constitutes a step toward the solution. Rarely does it constitute the complete solution. The admission "I cannot do something" is often the first step in solving a problem realistically.

6.3 Coping with a diagnosis

Illness is an emotionally as well as physically depriving experience. It can do lasting harm by threatening a person's sense of well-being, competence, and feelings of productivity.

Emotional reactions to illness may culminate in the feeling that life is meaningless. How people react to chronic illness depends on many conditions.

- The severity of the illness
- The social support available
- The pre illness personality of the person

The severity of the illness: If the person is seriously sick, he must put his energy into healing.

Social support available: If the person is willing to ask for help and has a wide support network, it will be easier than when isolated.

The pre- illness personality of the person: If the person had always been resilient, he will be able to develop resilience in coping with the illness.

The emotional trauma of chronic physical illness is caused by loss of a valued level of functioning. The chronically ill person not only suffers the loss of immediate competency but is deprived of an expectable future.

In the face of such losses, it is normal to experience fear, anger, depression, and anxiety

In-Text Question
The severity of the illness could affect how a person responds to illness. True or False

In-Text Answer
True

6.4 Coping and culture

There is a connection between culture and coping. Cultural beliefs influence how people react or cope in ill health. World view is culturally based and can also be influenced by our religious beliefs.

The figure below illustrates an African culture that could affect how they cope with illness

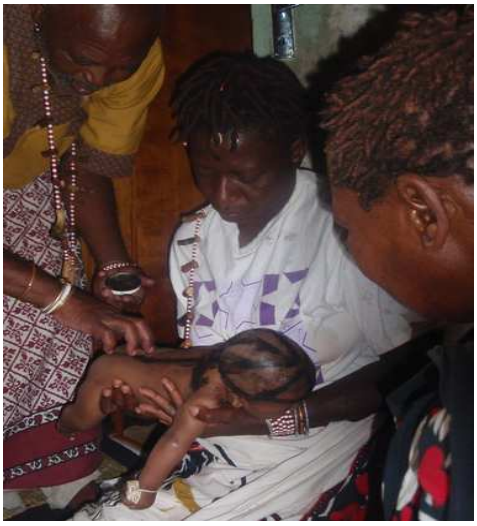


Figure1.1 *African culture*
Source:*http://upload.wikimedia.org/wikipedia/commons/8/8e/Sangoma_performing_a_Baptism.jpg*

Individualism vs. collectivism

Culturally-based worldviews and values affect how individuals respond to stress. Collectivistic values emphasize interpersonal relationships (i.e., family or other social support networks), respect for authority figures, intra-cultural coping and relational universality.

Western frameworks, however, do not capture the full distinctions of the coping strategies of individuals from communal and collectivistic cultures (i.e., Africa, Latin America, and Asia).

For example, forbearance, perseverance, and sacrifice are characteristics that are highly valued in collectivistic cultures. Consequently, individuals from these cultures may cope by not disclosing their problems to others because they do not want to burden others.

Cultural factors that can influence coping include discrimination and stigma which can erode resilience. Gender constraints could also be problematic. Guilt and shame can influence coping.

5 phase model of facing a potentially fatal illness.

The 5 phase models of facing a potentially fatal illness are:

- Pre-diagnostic phase
- Acute phase
- Chronic phase
- Recovery Phase
- Terminal Phase

Pre-diagnostic phase: This is an initial indicator of illness and disease.

Acute phase: It is a state of treatable condition

Chronic phase: It includes living with a life threatening illness. It involves managing symptoms and side effects, dealing with financial concerns and preserving self-concept.

Recovery Phase: Deals with after effects, anxiety about reoccurrence, reformulating of one's lifestyle.

Terminal Phase: It includes trying to find meaning from experience, saying goodbye and deciding what kind of care to have.

Activity : Coping and response

Time Allowed: 15 minutes

Discuss how your culture could affect coping response.

Summary

In this study session 6, you have learnt that:

1. **Lazarus** was one of the first individuals to develop a theoretical perspective about coping as a conscious process.
2. We can conceptualize coping strategies in multiple ways. They are:
   - Biological/physiological Coping
   - The cognitive component of coping
   - The learned component of coping
   - Intention
3. In the isolation stage of response in illness, the acute nature of the illness may decrease. But total recovery does not occur, and the illness persists. There is a dawning awareness of everyone's part that the situation has become a chronic one and that there will be no full recovery.
4. There are different stages of responses in illness .They are:
   a. Crisis
   b. Isolation
   c. Anger
   d. Reconstruction
   e. Intermittent Depression
   f. Renewal
5. Emotional reactions to illness may culminate in the feeling that life is meaningless.
6. People react to chronic illness based on many conditions. They are:
   - The severity of the illness
   - The social support available
   - The pre illness personality of the person

7. The 5 phase models of facing a potentially fatal illness are:
    - Pre-diagnostic phase
    - Acute phase
    - Chronic phase
    - Recovery Phase
    - Terminal Phase

Self-Assessment Questions (SAQs) for Study Session 6

Now that you have completed this study session, you can assess how well you have achieved its Learning outcomes by answering the following questions.

Write your answers in your study Diary and discuss them with your Tutor at the next study Support Meeting.

You can check your answers with the Notes on the Self-Assessment questions at the end of this Module.

SAQ 6.1 (Testing Learning outcomes 6.1)

Explain the physiological way of coping

SAQ 6.2 (Testing Learning outcomes 6.2)

Discuss how patients respond in the crisis stage of illness

SAQ 6.3 (Testing Learning outcomes 6.3)

Explain how a patient could cope with a diagnosis

SAQ 6.4 (Testing Learning outcomes 6.4)

Highlight some cultural traits that can influence coping

Notes on SAQs for study session 6

SAQ 6.1

The body has a natural method of coping with stress. Any threat or challenge perceived by an individual in the environment triggers a physiological chain of events. The sympathetic/adrenal system secretes epinephrine and norepinephrine. This is the “fight or flight” response.

SAQ 6.2

In the crisis stage, the patient is seriously ill and very frightened. There is decrease in his ability to respond to others psychologically and physically. The sick directs his energies toward healing, and controlling panic. The patient is often too sick to even be frightened.

Events are often confused. Time is distorted. Disorientation is common. At these times we fall back on our innate biological ability to heal. The support network is highly stressed. There is increase in anxiety, especially if the support network must carry the full responsibilities of arranging for medical care and handling finances.

The family's anxiety can be energizing. The family may feel a need, sometimes an obligation, to be highly supportive of the patient. During the crisis stage almost all of the patient's energy and attention are focused on responding to the physical onslaught of the illness. Surviving is the primary concern.

SAQ 6.3

Emotional reactions to illness may culminate in the feeling that life is meaningless. How people react to chronic illness depends on many conditions.

- The severity of the illness
- The social support available
- The pre illness personality of the person

The severity of the illness: If the person is seriously sick, he must put his energy into healing.

Social support available: If the person is willing to ask for help and has a wide support network, it will be easier than when isolated.

The pre- illness personality of the person: If the person had always been resilient, he will be able to develop resilience in coping with the illness.

The emotional trauma of chronic physical illness is caused by loss of a valued level of functioning. The chronically ill person not only suffers the loss of immediate competency but is deprived of an expectable future.

SAQ 6.4

Some of the cultural traits that can influence coping include the following:

1. Forbearance
2. Perseverance
3. Sacrifice
4. Discrimination

5. Stigmatization
6. Guilt
7. Shame

References

Cockerham, W. C. (2003). Medical Sociology. (9th edition). NY: Prentice Hall.

Glanz, K., Rimer, B.K., & Lewis, F.M. (2002). Health behavior and health education: Theory, research, and practice. San Francisco: Wiley & Sons.

Kinzbrunner, B.M., Weinreb, N.J. & Policzer, J.S. (2002) Common Problems: End of Life Care. McGraw-Hill.

Okun, B. & Nowinski, J. (2011) Saying Goodbye Berkley Publishing Group, Harvard University.

Weiss, L. G. and Lonnquist, L. E. (2005). The Sociology of Health, Healing and Illness, fifth edition, Safari book online. http//www.safarix.com/.Accessed April, 2014.

Study Session 7: Coping with the crisis of illness

Introduction

Bad events occur every day all over the world. From earthquake to tsunami, from tsunami to plane crash and list is endless. Crises abound every day. Illness in every context is not a good one and could be considered a crisis.

In this study session, you will learn about the crisis theory, the defense mechanism of patients, the meaning of grief and mourning and how to assess a grieving patient, factors that influence how people cope when they grieve and the responsibility of a family when they grieve.

Learning outcomes for study session 7

At the end of this study session, you should be able to:

7.1. Explain the crisis Theory
7.2 Discuss the ego defense mechanism
7.3 Enumerate the types of defence mechanism
7.4 Discuss the responses of patients and their families to terminal illnesses
7.5 Explain how to access a grieving patient.
7.6 Highlight factors that Influence how people cope when they grieve
7.7 Explain the responsibilities of a family during grieving.
7.8 Discuss grief as a family matter.

7.1 Crisis Theory

Illness is a crisis because it is a turning point in an individual's life. Disorder to established patterns of personal and social functioning produces a state of psychological, social, and physical disequilibrium. Restoring equilibrium involves finding new ways of coping with drastically altered circumstances

The crisis theory described the factors that affect people's adjustment to having serious illness (Moos, 1982). The coping process (3 stages) is influenced by three factors and also determines the outcome of crisis.

The three factors are:

- Illness related factors
- Background and personal factors
- Physical , social and environmental factors

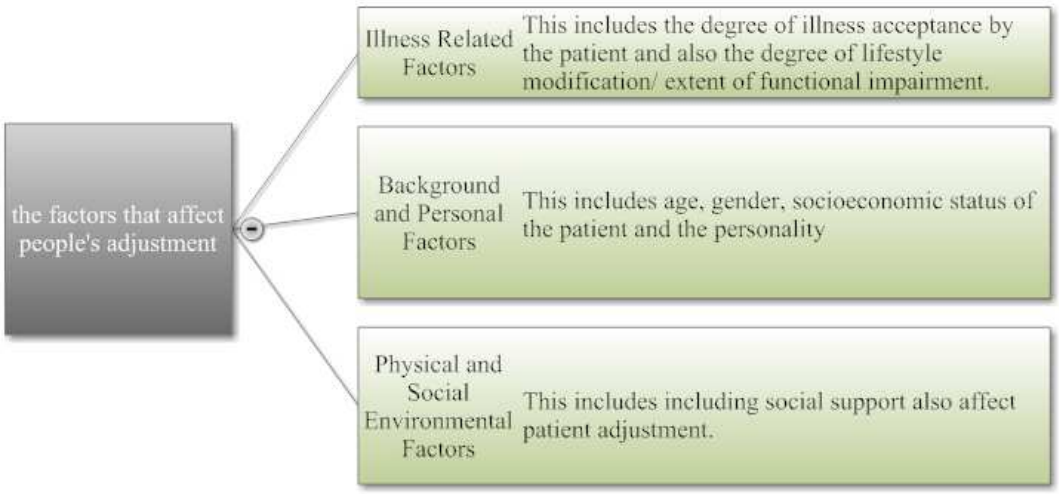


Figure 1.1: *The three stages of the coping process*

The coping process includes:

- Cognitive appraisal
- Adaptive tasks
- Coping skills
- Adaptation and Adjustment.
- General task

- **Cognitive appraisal:** It involves the logical analysis and cognitive redefinition of the meaning or significance of the illness, the threats and coping ability.
- **Adaptive tasks**: It involves formulation of tasks that help in coping with illness and general psychosocial functioning in terms of self-perception and self-esteem.
- **Coping skills**: It deals with seeking information, support and taking problem solving actions like denial, goal setting, recruiting support, and catharsis.
- **Adaptation and Adjustment**: It is the physical, vocational, self-concept, social, emotional, compliance with illness.
- **General tasks**: It deals with reservation of emotional balance, self-image, and maintenance of relationship with family & friends.

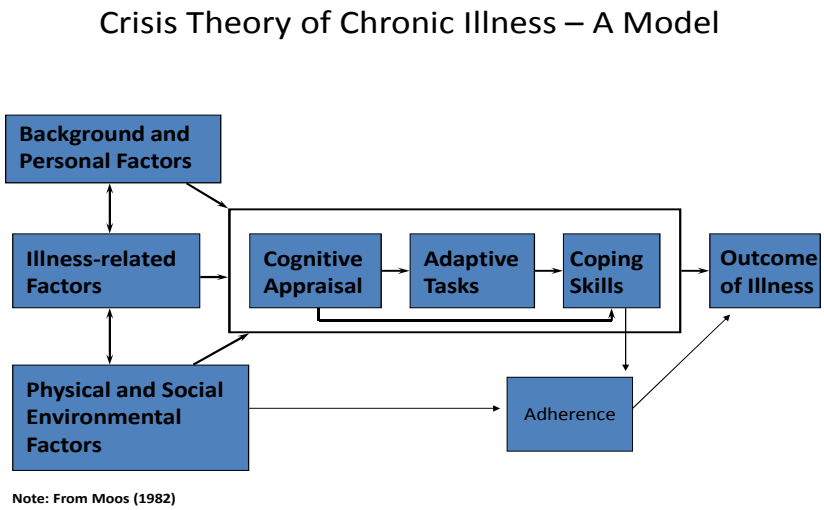


Figure 1.2: *The crisis theory of chronic illness.*

7.2 Ego Defense Mechanism

These are unconscious behaviors that offer psychological protection from a stressful event. It is used by everyone and helps to protect against feelings of unworthiness and anxiety. Stress calls for adjustments.

In Text Question

……..involves the logical analysis and cognitive redefinition of the meaning or significance of the illness, the threats and coping ability.

In Text Answer

Cognitive appraisal

Here are two types of adjustments. They are:

Direct coping
Defensive coping.

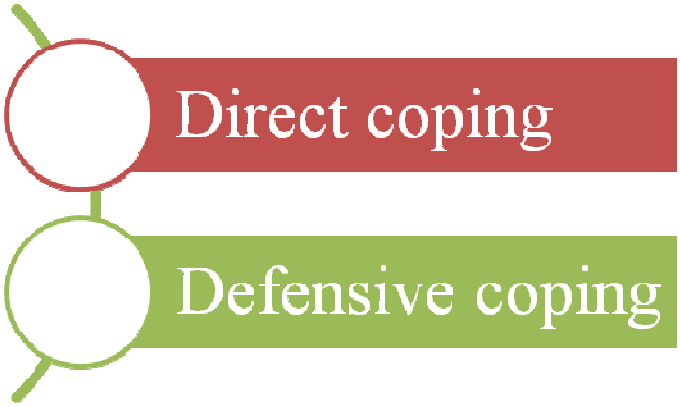


Figure 1.3: *Types of adjustments*

Direct coping

It refers to any action that we take to change an uncomfortable situation. When our needs or desires are frustrated, we attempt to remove the obstacles between ourselves and our goal, or we give up. Similarly, when we are threatened, we try to eliminate the source of the threat, either by attacking it or by escaping from it.

Direct coping involves:

- Confrontation
- Compromise
- Withdrawal

Confrontation

Confrontation means facing a stressful situation directly. It involves acknowledging to oneself that there is a problem for which a solution must be found. It means attacking the problem head on, and pushing resolutely toward one's goal.

It may require trying to change either oneself or the situation. Confrontation may also include expressions of anger. Anger can be effective, especially if we have really been unfairly treated, if we express our anger with restraint instead of exploding in rage.

Compromise

Compromise is one of the most common and effective way of coping directly with conflict or frustration. We often recognize that we cannot have everything we want and that we cannot expect others to do just as we would like them to do. In such cases, we may decide to settle for less than we originally wanted.

In Text Question

When you face a stressful situation directly it is referred to as…….

In Text Answer

Confrontation

Withdrawal

In some circumstances, the most effective way of coping with stress is to withdraw from the situation. We often equate withdrawal with simply refusing to face problems. But when we realize that our adversary is more powerful than we are, or that there is no way, we can effectively change ourselves, alter the situation, or reach a compromise.

We withdraw if the situation is in fact hopeless .Resignation withdrawal may be the most effective way of coping.

Defensive coping

There are times when we cannot identify or deal directly with the source of our stress. In such cases, people are likely to use defensive mechanisms as a way of coping. Defense mechanisms are ways of deceiving oneself about the causes of stressful situation so that pressure frustration, conflict and anxiety are reduced.

7.3 Types of Defense Mechanism

There are different types of defense mechanism.

They are:

1. Repression
2. Denial
3. Suppression
4. Rationalization
5. Intellectualization
6. Identification
7. Introjection
8. Compensation
9. Reaction formation
10. Displacement
11. Projection
12. Conversion
13. Undoing
14. Dissociation
15. Regression
16. Sublimation

17.

- **Repression:** Unconscious and involuntary forgetting of painful ideas, events, and conflicts.
- **Denial:** Unconscious refusal to admit an unacceptable idea or behavior.
- **Suppression:** Voluntary exclusion from awareness of anxiety-producing feelings, ideas, and situations.
- **Rationalization:** Attempts to make or prove that one's feelings or behaviors are justifiable
- **Intellectualization:** Using only logical explanations without feelings or an affective component.
- **Identification:** A conscious or unconscious attempt to model oneself after a respected person.
- **Introjection:** Unconsciously incorporating wishes, values and attitudes of others as if they were your own.
- **Compensation:** Covering up for a weakness by overemphasizing or making up a desirable trait.
- **Reaction formation:** A conscious behavior that is the opposite of an unconscious feeling.
- **Displacement:** Discharging contained feelings to a less threatening object.
- **Projection:** Blaming someone else for one's difficulties or placing one's unethical desires on someone else.
- **Conversion:** The unconscious expression of intra-psychic conflict symbolically through physical symptoms.

In Text Question

From this study ……..… Means to Cover up for a weakness by overemphasizing or making up a desirable trait.

In Text Answer

Compensation

1. **Undoing:** Doing something to counteract or make up for a transgression or wrongdoing.

2. **Dissociation:** The unconscious separation of painful feelings and emotions from an unacceptable idea, situation, or object.

3. **Regression:** The personality loses developmental achievements and reverts to an earlier level of behavior.

4. **Sublimation:** Transformation and channeling of unacceptable impulses, desires, and behaviors into socially accepted behaviors

7.4 Grief and Mourning

Grief is an emotional reaction/response to loss. Grief and has many stages. The process begins with a life-threatening diagnosis, proceeds through a period of treatment (or treatments), and ends eventually in death. This process means that both the terminally ill individual and the family are increasingly confronted with the need to "live with death" for a prolonged period of time.

Figure 1.4 an expression of mourning and grief

Source:http://upload.wikimedia.org/wikipedia/commons/4/46/Parents_of_Chibok_kidnapping_victims.png

This protracted process not only leaves individuals to mourn but typically draws in the entire family of the dying person for months or even for years, with the potential of altering the lifestyles. Bereavement practices can be greatly influenced by cultural and religious beliefs. Nursing by its nature is involved in all processes of life from birth to death.

Nurses interact daily with clients and families experiencing loss and grief. It is important for nurses to have an understanding of these beliefs in order to provide culturally sensitive care to their clients

Mourning is the process one undertakes to deal with the void that is now left. Mourning is the process of adjusting to living a life without this special someone or something. It is period of adapting to the changes created by this loss.

In Text Question

The process that begins with a life-threatening diagnosis proceeds through a period of treatment (or treatments), and end eventually in death is known as…….

In Text Answer

Grief

Mourning is the outward expression of grief. It is usually based on cultural, religious, or personal belief systems. Examples of mourning include visiting the gravesite of a loved one on special dates, keeping a journal or making a photo album of the deceased. All of these expressions are normal and it's important to remember that mourning is a very personal expression of grief. There is no right or wrong way to do it.

7.5 Responses of clients and their families to terminal illness and Impending death.

Grief is a bereaved person's internal emotional response to the loss event. It has several components: physical, behavioral, emotional, mental, social, and spiritual. It is often described by those that have gone through it as a heaviness that isn't easily lifted. It can sometimes be so pronounced that it affects a person's physical self and can even mimic illnesses.

Grief has two responses. They are:

- Normal response
- Abnormal response

Figure1.5 Grief Responses

Normal Grief

Grief that is eventually lessened as a person readjusts to their loss. Grief is usually not something one "recovers" from because the loss is never regained or replaced. For majority it changes their entire identity and they will divide their lives into "before" the loss and "after" the loss

Abnormal Grief

Abnormal grief is complicated grief. It can be divided into:

- Chronic grief
- Delayed grief
- Disenfranchised grief
- Exaggerated grief
- Sudden grief

Chronic grief: The grieving individual has trouble finding closure and returning to normal activities over an extended amount of time.

Delayed grief: This is intentional postponement of grief.

Disenfranchised grief: It often occurs when a grieving person's loss can't be openly acknowledged as a real loss e.g. losses related to AIDS, miscarriage.

Exaggerated grief: Intense reactions of grief that may include nightmares, phobias (abnormal fears), and thoughts of suicide.

Sudden grief: It occurs when death takes place very suddenly without warning e.g. post-traumatic stress disorder (PTSD).

In Text Question

The grief that is eventually lessened as a person readjusts to his loss is called _____.

In Text Answer

Normal grief

7.6 Assessment of the Grieving Client

To assess the grieving client, some factors are taken into considerations.

They are:

1. Developmental considerations
2. Nature of relationship with the ill or dead
3. Nature of the loss
4. Cultural and spiritual beliefs
5. Gender roles
6. Socioeconomic status/ social support system

Developmental considerations

This has to do with Age of the grieving client. It could be a toddler, preschooler, school-age, young adult, middle age or the elderly.

Infancy to 5 years (preschool): The infants has little or no understanding of death, death is temporary and reversible, like sleep

6 to 9 years (school age): For the school age death is final and personal death can be avoided. Death is related to violence.

10 to 12 years (preadolescent): This age group considers death is an inevitable end to life.

13 to 18 years (adolescent): The adolescent is afraid of prolonged death, has religious approach to death and rarely think about death

19 to 45 years (young adulthood): The young adulthood cultural and religious beliefs influence their attitudes and death is seen as a future event

45 to 65 years (middle adulthood): This group accepts mortality as inevitable and witnesses death of parents and peers. This may cause death anxiety

65 years and older (older adulthood): They are afraid of prolonged health problems. They witness death of family members and peers .This makes them see death as inevitable.

Nature of relationship with the ill or dead: Individuals that has close relationship with the ill or dead do not recover easily from grief.

Nature of the loss: It could be a change in self-image, developmental changes, loss of possessions or loss of significant others

Cultural and spiritual beliefs related to illness or death: Some individuals spiritual beliefs could either make them recover fast or go into deep grief.

Gender roles: Men tend to rely heavily on a close relationship with their spouse, placing less importance on relationships with other people. Because of their smaller social network, men are more vulnerable to social isolation after the loss of a spouse.

Socioeconomic status/ social support system: A person's extent of grief could actually be as a result of the financial implication or the kind of monetary support they normally get from the deceased while he was alive

---

Activity 1.1 Assessing a grieving client

Time Allowed: 10 minutes

Discuss some factors you would consider when assessing a grieving client.

7.7 Factors That Influence Coping During the Grieving Process

There are several factors that influence coping during the grieving process

They are:

- Dying trajectories
- Awareness contexts

- **Dying trajectories**: It states how the shape and duration of a person's death trajectory influence coping.
- **Awareness contexts**: It is the interactions among those who are coping with dying with an emphasis on the levels of openness and honesty between them.

  There are four types of awareness (these are not stages).

  - Closed Awareness
  - Suspected Awareness
  - Mutual Pretense
  - Open Awareness

Closed Awareness: The Family and patient himself recognize that he is ill but lack awareness relating to impending death. Is this fair? How long can it be maintained?

Suspected Awareness: The person that is ill suspects that he was not given the full story about the illness; it undermines trust.

Mutual Pretense: The patient, family, and care providers know of the terminal prognosis but no one discusses the issue openly. People make every effort to avoid the subject. It requires constant vigilance and is very draining.

Open Awareness: It is preferred by health care providers and patients .It involves free and open discuss on the impending death.

There are several fears associated with terminal illness and death. They are:

- Fear of pain
- Fear of loneliness
- Fear of meaninglessness

Fear of pain: it is the tendency to associate death with pain. Pain control measures should be available to client to relieve pain and discomfort.

Fear of loneliness: Most terminally ill patients don't want to be alone, many patients are afraid they will be abandoned by loved ones who can't cope with their imminent death

Fear of meaninglessness: Patients close to death tend to review and examine their actions. For some it is usually an expression of regrets about what they fail to do. Patients need to look at positive aspects of their lives .The dying person needs to express his worth.

In Text Question

It is preferred by health care providers and patients and involves free and open discuss on the impending death. What kind of awareness is that?

In Text Answer

Open Awareness

7.8 Grief is a family matter

Grief today is a family matter as much as it is an individual one. The family includes the blood relations and all those who have a significant connection to the person who carries the diagnosis.

The challenges that families must face when confronted with a terminal diagnosis of a loved one are complex It involves learning how to cope with setbacks and deterioration as well as periods of seeming remission and also dealing with the complexities of extended grief, which can wear individuals down and lead at times to uncertainty or unpleasant feelings.

Family members are forced by circumstances to cope with prolonged grief and are vulnerable to serious psychological consequences, including depression, guilt, and draining anxiety. These circumstances can even lead to physical illness

Five-stage model of family grief

There are no hard-and-fast boundaries separating these stages. While virtually every family will experience each stage, one should not expect one stage to simply end and another to begin.

The stages are:

- Crisis
- Unity
- Upheaval
- Resolution
- Renewal

Stage 1: Crisis

The diagnosis of a terminal illness or a potentially terminal illness creates a crisis for the family. It disrupts the family's equilibrium, just as a rock thrown into the middle of a still pond disrupts its equilibrium.

Anxiety is the most common initial reaction to the news that a family member is terminally ill. If the terminally ill person is a child or young adult, anger at the seeming injustice of early death may be the dominant emotion shared by family members at this initial stage.

All adult family members will benefit from guidance issues such as what to expect in terms of their own emotional reactions, whom to seek support from, whom to share memories and emotions, with, and what to expect when they meet with the dying loved ones and other family members.

Factors that affect how you may react at this stage include**:**

- The history as well as the current status of your relationship with the family member that is ill
- The type of relationship you have with the Patient E.g. spouse, parent or a child.
- The patient's past and present roles in the family

Stage 2: Unity

The reality of impending death has effect on family members to put longstanding complaints or grudges on hold as they pull together to move into this second stage of grieving. The needs of the dying become paramount.

A major issue for all family members is how they will define their roles with respect to one another and the terminally ill member **.**They will also determine type of care their family member that is ill needs.

How the family organizes itself so as to complete these tasks can have powerful psychological effects on each member, depending on how comfortable each feels with the role he or she is playing.

Stage 3: Upheaval

The unity that characterizes Stage 2 begins to wear thin as the lifestyles of all involved, whether they recognize it or not, gradually undergo some significant changes. Many people experience ambivalence (mixed feelings) when the process of dying evolves into a protracted (prolonged) one in which the loved one's overall quality of life slowly deteriorates.

Emotions such as guilt, anger, and resentment are likely to emerge. Suppressing thoughts and feelings about such upheavals can lead to strained relationships and eventually can cause the entire family to fall apart.

Stage 4: Resolution

As a family moves into the fourth stage of grief, the terminally ill loved one's health is typically marked by gradual deterioration, punctuated perhaps by periods of stabilization or temporary improvement, and the effects of the prolonged grief process can and should no longer be ignored.

Family members often find themselves having more memories (good and bad) of past experiences which usually reflect relationships with the patient. Some of these memories may evoke feelings of joy or nostalgia; others, however, may evoke anger, jealousy, or envy.

It is also an opportunity to resolve longstanding issues, heal wounds, and redefine one's role in the family. In this way the process of family grief can set the stage for growth and renewal for all involved.

Stage 5: Renewal

The final stage of grief actually begins with the funeral and the celebration of the life of the now-lost family member. This is a time of mixed emotions, **(**sadness and relief**)**. If the family has successfully negotiated the previous four stages, this final stage also opens yet another door to collective as well as personal renewal. It is also a time for looking forward, to revitalized relationships and to new family traditions.

In-Text Question

The model of family grief include the following except_____
(a) Crisis (b) Unity (c) Resolution (d) Decision

In-Text Answer

(d) Decision

Self-Assessment Questions (SAQs) for Study Session 7

Now that you have completed this study session, you can assess how well you have achieved its Learning outcomes by answering the following questions.

Write your answers in your study Diary and discuss them with your Tutor at the next study Support Meeting.

You can check your answers with the Notes on the Self-Assessment questions at the end of this Module.

SAQ 7.1 (Testing Learning outcomes 7.1)

Explain the crisis theory

SAQ 7.2 (Testing Learning outcomes 7.2)

Highlight the two types of adjustments

SAQ 7.3 (Testing Learning outcomes 7.3)

Explain rationalization and Intellectualization defense mechanisms

SAQ 7.4 (Testing Learning outcomes 7.4)

What is the major difference between grief and mourning?

SAQ 7.5 (Testing Learning outcomes 7.5)

Explain the abnormal response to grief

SAQ 7.6 (Testing Learning outcomes 7.6)

How does 65 years and older age group perceive grief?

SAQ 7.7 (Testing Learning outcomes 7.7)
Highlight the several fears associated with terminal illness

SAQ 7.8 (Testing Learning outcomes 7.8)
Discuss the crisis stage of the model of family grief.

Notes on SAQs for study session 7

SAQ 7.1

The crisis theory described the factors that affect people's adjustment to having serious illness (Moos, 1982).

SAQ 7.2

The two types of adjustments are:

- Direct coping
- Defensive coping.

SAQ 7.3

Rationalization: Attempts to make or prove that one's feelings or behaviors are justifiable

Intellectualization: Using only logical explanations without feelings or an affective component.

SAQ 7.4

Mourning is the outward expression of grief. It is the process one undertakes to deal with the void that is now left

SAQ 7.5

Abnormal grief is complicated grief. It can be divided into:

- Chronic grief
- Delayed grief
- Disenfranchised grief
- Exaggerated grief
- Sudden grief

SAQ 7.6

They are afraid of prolonged health problems. They witness death of family members and peers .This makes them see death as inevitable.

SAQ 7.7

There are several fears associated with terminal illness and death. They are:

- Fear of pain
- Fear of loneliness
- Fear of meaninglessness

SAQ 7.8

The diagnosis of a terminal illness or a potentially terminal illness creates a crisis for the family. It disrupts the family's equilibrium, just as a rock thrown into the middle of a still pond disrupts its equilibrium.

Anxiety is the most common initial reaction to the news that a family member is terminally ill. If the terminally ill person is a child or young adult, anger at the seeming injustice of early death may be the dominant emotion shared by family members at this initial stage.

All adult family members will benefit from guidance issues such as what to expect in terms of their own emotional reactions, whom to seek support from, whom to share memories and emotions, with, and what to expect when they meet with the dying loved one and other family members.

References

Cockerham, W. C. (2003). *Medical Sociology.* (9th edition). NY: Prentice Hall.

Glanz, K., Rimer, B.K., & Lewis, F.M. (2002). *Health behavior and health education: Theory, research, and practice*. San Francisco: Wiley & Sons.

Kinzbrunner, B.M., Weinreb, N.J. & Policzer, J.S. (2002) *Common Problems: End of Life Care*. McGraw-Hill.

Okun, B. & Nowinski, J.(2011) *Saying Goodbye* Berkley Publishing Group, Harvard University.

Weiss, L. G. and Lonnquist, L. E. (2005). *The Sociology of Health, Healing and Illness*, fifth edition, Safari book online. http//www.safarix.com/.Accessed April, 2014.

Study Session 8: Influences on the sick

Introduction

The problems associated with chronic illness will ultimately affect the various domains (aspects) of not only the patient's life but also that of the significant others like the family etc. The physical, psychological, economic, and social dimensions are affected.

Therefore in this study you will learn about the domains of the patient's life affected by chronic illness, the impact of chronic illness on families, the factors influencing how families react to chronic illness, reactions to hospitalization across ages and the role of the nurse in hospitalization**.**

Learning outcomes for study session 8

At the end of this study, you should be able to:

8.1 Explain the domains of the patient's life affected by chronic illness
8.2 Discuss the impact of chronic illness on families
8.3 Highlight the factors influencing how families will react to chronic illness
8.4 Discuss the reactions to hospitalization across ages
8.5 Highlight the role of the nurse during and at the end of hospitalization

8. 1 Domains of the patient's life affected by chronic illness

There are several domains (fields) of the patient's life affected by chronic illness. They are:

- Physical domain
- Psychological Domain
- Economic Domain
- Social Domain

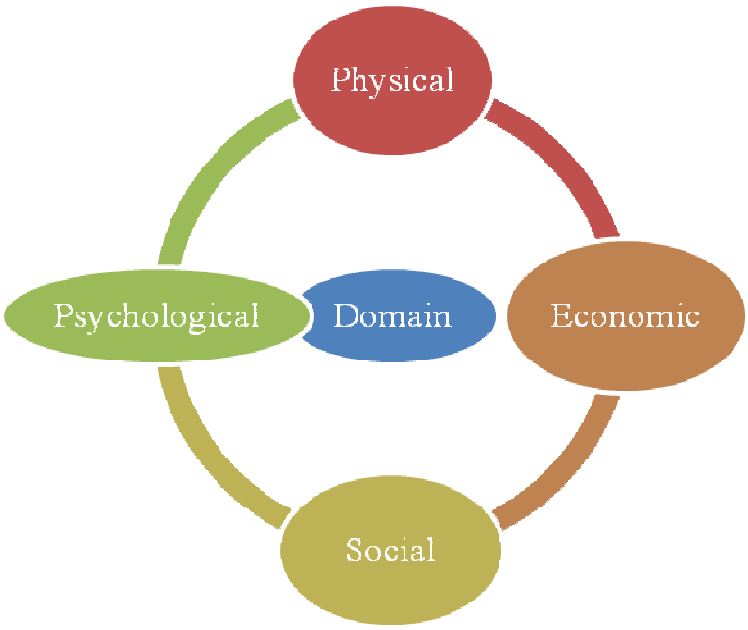


Figure 1.1: Domain of Patient's life affected by chronic illness

Physical Domain

The physical domain of the patient's life can be assessed by taking into consideration his:

- Functional Status
- Physical Symptoms

Functional Status

This refers to the patient's ability to continue functioning in his/her daily activities, such as self-care, going to work or school, participating in recreational activities, and continuing with activities that the patient enjoyed prior to the chronic condition.

Physical Symptoms

Due to the nature of chronic illness and its long-term symptoms, the patient is continually reminded of his/her condition. The symptoms include the symptoms of the chronic illness and the side effects from the treatment that is prescribed.

Psychological Domain

The psychological domain of patients includes:

- Grief and Sorrow
- Fears

Grief and sorrow

Loss, sorrow and the resultant grief are characteristics of patients coping with chronic illness. There is grief of the loss of a body part and of physical functioning. Variables

such as age, gender, health before the diagnosis of the illness, and the patient's existing social support determine the type of support that will be experienced.

Fears

Patients with chronic illness experience a variety of fears due to the uncertainty of the diagnosis of their illness, difficulties in understanding the medical jargons, inadaptability to medical regimens and new schedules, and feeling a loss of control over their lives.

Irene Pollin, an internationally acclaimed health advocate highlighted eight fears that a patient with chronic illness experiences. They are:

1. Loss of control
2. Loss of self-image
3. Loss of independence
4. Stigma
5. Abandonment
6. Expression of anger
7. Isolation
8. Death.

Economic Domain

Chronic illness is emotionally and financially draining. Due to the incapacitating effects of the illness, patients may find themselves giving up their jobs. The patient's family may also experience loss of income, particularly those family members who have to forfeit their jobs to assist with caregiving activities.

Social Domain

Due to their limited functional abilities, some patients with chronic illness may decrease their level of participation in social activities, thereby altering their social life. Due to certain illnesses, family and friends may withdraw from the patient. When a patient is diagnosed with a chronic illness, the issue of mortality becomes a source of concern for the patient and his social network.

In-Text Question

The domains (fields) of the patient’s life affected by chronic illness are the following except.

(a) Physical domain (b) Psychological Domain(c) Scientific domain (d) Economic
(b) Domain

In-Text Answer

(c) Scientific domain

8.2 Impact of chronic illness on families.

All families go through normal challenges that are related to life cycles and situational stressors. However, families living with chronic illness confront a new set of demands related to that illness. Some of such demands include:

- Financial Stressors and Strains
- Social Demands
- Psychological Demands

Financial Stressors and Strains

Chronically ill patients and their families often experience financial strains due to frequent hospitalizations, medical and therapeutic treatments. For those families who are wealthy, a family member may have to leave his/her employment in order to care for the patient.

Family demands related to care may either prevent a family member from receiving a promotion or result in the loss of a job. Medical visits, therapy, special equipment, medicines, and other specialized services are part of the financial demands associated with chronic illness.

For those families who are already financially stressed, chronic illness may place them at additional risk of draining their resources. It has been shown that financial resources are crucial predictor to family coping and adjustment to chronic illness.

Social Demands

When families have a family member with chronic illness, their social spheres will inevitably be affected. The responsibility for caring for a chronically ill patient, can strain marital relationships.

Marital satisfaction can be compromised because the communication process between the spouses may be hampered. The level of marital satisfaction is ultimately affected by the wife's perceived support from her spouse.

Siblings in a family system are also affected. Studies have shown that siblings of a chronically ill family member are vulnerable to adjustment problems, low self-esteem, poor peer relations, anxiety, and depression.

Parents may have less physical and emotional time to spend with siblings to help them adjust to the effects of chronic illness on the family system. In addition, the degree to which the siblings are affected is also influenced by the severity of the condition.

Psychological Demands

Both the patient and family mourn over the loss of what could have been the hopes, dreams, and possibilities of the family member that is ill. There may be uncertainty about the roles, rules, and boundaries in the family system as a result of the patient's illness.

Activity 1.1 Impact of chronic illness on families

Time Allowed: 15 minutes

Discuss how chronic illness affects the family and the society at large

8.3 Factors influencing how families will respond to chronic illness

Variations exist in how families respond to the consequences of chronic illness. These variations are influenced by the following

- Nature and characteristics of the condition,
- Resources
- Illness phases
- Family life stage
- Gender.

Nature and Characteristics of the Illness

How a family adapts depends more on the characteristics of the illness. These characteristics include:

1. Degree and type of incapacitation (e.g., sensory, motor, cognitive)
2. Extent of visibility of the condition, prognosis or life expectancy (e.g., is the outlook negative or positive; is it a terminal illness)
3. Course of the illness (e.g., constant, relapsing, or progressive),
4. Amount of home treatment (outpatient and inpatient medical treatment)
5. Expertise needed for the patient,
6. The amount of pain or other symptoms experienced.

Resources

Families possess three types of resources. They are:

- Personal Resources
- Social/Familial Resources
- Community Resources

Personal Resources: These refer to the family's inherent resources for dealing with the challenge of chronic illness. These resources include their socioeconomic status, level of coping skills, self-efficacy, sense of mastery, and their own physical health.

Social/Familial Resources: These refer to the availability of social support networks in families, including confidants, friends, and extended family members. Social support is an important moderating variable.

How a family responds to chronic illness could be determined by its social support system, which includes family, friends, neighbors, and community resources. Familial resources refer to the organization of the family, such as clarity of rules and expectations, routines for daily family tasks, clear generational boundaries, and good communication.

Community Resources

This refers to the quality of relationships that families have with professionals who are providing care and other services to the family members. Contact with professionals reliable in family dynamics could ease the strain of chronic illness.

Illness Phases

Neither illness nor family coping is static; rather, it is dynamic. How a family responds to chronic illness is also a function of the phase of the illness. This is because each phase of the illness has specific demands and transitions. Families will require different strengths, resources, and reorganization to meet these psychosocial demands. The illness phase could be divided into the following phases

- Crisis Phase
- Chronic Phase
- Terminal Phase

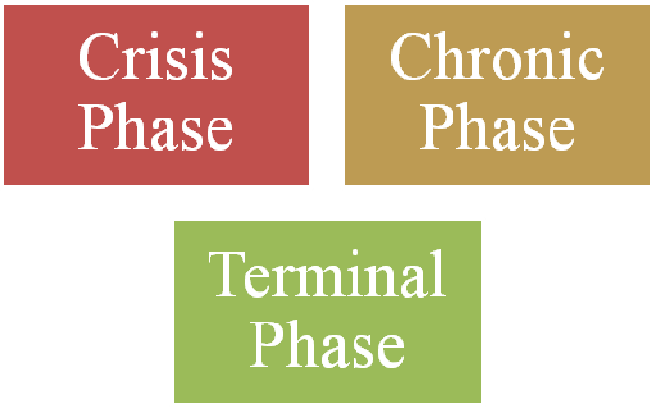


Figure 1.2: Illness phase

Crisis Phase

This time period includes the symptomatic period prior to the diagnosis and the initial period of coping and adjustment after the diagnosis. Families in this phase must learn to cope with the symptoms related to the condition, navigate the medical and healthcare system, and manage the day-to-day responsibilities of caring for the patient

Chronic Phase: This phase is characterized as the "long haul," which include the day-to-day activities and tasks related to caring for the patient and the family's attempt to maintain a semblance of normalcy. Family members reallocate roles and work on maintaining individual independence in the family system.

Terminal Phase: This period is marked by the imminence of death, and family members struggle to deal with issues of separation, mourning, and resuming family life after the loss.

Family Life Stage: Families who have a family member with a chronic illness have different needs, strengths, and resources at various points in the family life cycle. In a family with young children, for example, when one of the parental figures is diagnosed with a devastating disease, the impact on child-rearing tasks can be affected in several ways.

Role of Gender

Gender is another important variable that influences how a family responds to chronic illness. The term "feminization of care" refers to the notion that most women are caregivers and expected to provide caregiving duties. The competing demands of balancing full-time work, caring, nurturing their own children, and maintaining their own homes contribute to the caregiving stress and burden on women.

In-Text Question

How a family responds to chronic illness is also a function of the phases of the illnesses. True or False

In-Text Answer

True

8.4 Reactions to Hospitalization across ages

Age affects individual reactions to hospitalization and also the meaning of an illness or disaster. The categories of such age to consider are:

1. Infancy to 5 years (preschool)
2. Six to 11 years (school age)
3. 10 to 12 years (preadolescent)
4. 13 to 18 years (adolescent)
5. 19 to 45 years (young adulthood)
6. 45 to 65 years (middle adulthood)
7. 65 years and older (older adulthood)

Infancy to 5 years (preschool)

It is characterized by helplessness, passivity, generalized fear, heightened arousal, mental confusion, difficulty in talking about event, sleep disturbance, separation fears/clinging, regressive symptoms, anxiety about death, grief, somatic symptoms, startled response to loud or unusual noises, and irritability.

6 to 11 years (school age)

It is characterized by feelings of responsibility, guilt, traumatic play and retelling, sleep disturbance, anger, aggression, change in behavior, mood, personality, somatic symptoms, fear and anxiety, regression, separation anxiety, withdrawal, loss of interest in activities, magical thinking, loss of ability to concentrate, school avoidance and decline in school performance.

10 to 12 years (preadolescent)

It is characterized by disturbance, anger/aggression, change in behavior, mood, personality, somatic symptoms, fear and anxiety and fear of death fear.

13 to 18 years (adolescent)

They show Self-consciousness, life-threatening re-enactment, abrupt shift in relationships, depression, social withdrawal, sleep/eating disturbances, decline in school performance, rebellion, accident proneness, wish for revenge and action-oriented response. They are afraid of prolonged death, may act out defiance for death through dangerous or self-destructive acts and seldom think about death.

19 to 45 years (young adulthood*)*

Cultural and religious beliefs influence attitudes, and death is seen as a future event

45 to 65 years (middle adulthood)

This age bracket accepts mortality as inevitable and may experience death anxiety.

65 years and older (older adulthood).

They are afraid of prolonged health problems. They see death as inevitable and may mean freedom from discomfort.

In-Text Question

The ----------is characterized by helplessness, passivity, and generalized fear

In-Text Answer

Infancy to 5 years (preschool)

8.5 Role of the nurse during and at the end of hospitalization

The nurse and the client work together to assist the client to grow and solve his problems. This type of relationship is known as **therapeutic relationship**. In this relationship the nurse should be able to perceive and experience the feelings of the patient. She should understand the patient.

Figure 1.3: A nurse

Source:http://upload.wikimedia.org/wikipedia/commons/b/b2/Nurse_from_Uganda_helps_protect_womens_health_%286188985167%29.jpg

The nurse must be sincere and honest in her relationship with the patient. Consistency expresses sincerity which in turn fosters the development of the patient's trust.

The nurse should treat the patient with dignity. This is manifested when the nurse does not belittle or judge the patient's feelings, verbalizations and behaviors.

The phases in the nurse- patient relationship include:

- Orientation Phase
- Identification / working phase
- Termination/ resolution phase.

Orientation phase:

At this phase of the relationship, the nurse establishes a therapeutic environment where roles, goals, rules and limitations of the relationship are defined. The nurse gains the trust of the client and they establish a mode of acceptable communication.

Acceptance is the foundation of all therapeutic relationship and rapport is built by demonstrating acceptance and non-judgmental attitude. During this phase, the problems are not yet resolved but the client's feelings especially anxiety is reduced, by using

relaxing measures, to enable the client to relax enough to talk about his distressing feelings and thoughts.

Working/ Exploration/ Identification Phase:

During this phase, the client's problems are identified and solutions are explored, applied and evaluated. The focus of the assessment and of the relationship is the client's behavior and the focus of the interaction is the client's feelings.

The nurse should realize that the client's feelings of security are developed by being consistent at all times. Perception of reality, coping mechanisms and support systems are identified.

The nurse assists the patient to develop coping skills, positive self-concept and independence in order to change the behavior of the client to one that is adaptive and appropriate.

Termination/ Resolution Phase

Preparation of the termination phase begins at the orientation phase, when the duration and length of the nurse-client relationship was established. The nurse terminates the relationship when the mutually agreed goals are met, the patient is discharged.

The focus of this stage is the growth that has occurred in the client and how the nurse has helped the patient to become independent and responsible in making his own decisions. Client may become anxious and react with increased dependence, hostility and withdrawal; these are normal reactions and are signs of separation anxiety.

These feelings and behavior should be discussed with the client. The nurse should be firm in maintaining professionalism until the end of the relationship. Referral for continuing health care and support after discharge provides additional resources for the client and the family.

The goal of the therapeutic relationship have been met when the patient has developed emotional stability, cope positively, recognized sources or causes of anxiety, demonstrates ability to handle anxiety and independence, and is able to perform self-care. It is normal for the client to experience separation anxiety such as sleeplessness, anorexia, physical symptoms, withdrawal and hostility.

In-Text Question

The phases in the nurse- patient relationship include the following except

(a)Orientation Phase (b) Termination/ resolution phase. (c) Determination Phase

In-Text Answer

(a) Determination Phase

Summary

In study session 8, you have learnt that:

1. There are several domains (fields) of the patient's life affected by chronic illness. They are:
   - Physical domain
   - Psychological Domain
   - Economic Domain
   - Social Domain
2. When families have a family member with chronic illness, their social spheres will inevitably be affected
3. Chronically ill patients and their families often experience financial strains due to frequent hospitalizations, medical and therapeutic treatments
4. Variations exist in how families respond to the consequences of chronic illness. These variations are influenced by the following :
   - Nature and characteristics of the condition,
   - Resources
   - Illness phases
   - Family life stage
   - Gender
5. Age affects individual reactions to hospitalization and also the meaning of an illness or disaster. The categories of such age to consider are:
   A. Infancy to 5 years (preschool)
   B. Six to 11 years (school age)
   C. 10 to 12 years (preadolescent)
   D. 13 to 18 years (adolescent)
   E. 19 to 45 years (young adulthood)
   F. 45 to 65 years (middle adulthood)
   G. 65 years and older (older adulthood
6. At the orientation phase of the nurse-patient relationship, the nurse establishes a therapeutic environment where roles, goals, rules and limitations of the relationship are defined.

Self-Assessment Questions (SAQs) for Study Session 8

Now that you have completed this study session, you can assess how well you have achieved its Learning outcomes by answering the following questions.

Write your answers in your study Diary and discuss them with your Tutor at the next study Support Meeting.

You can check your answers with the Notes on the Self-Assessment questions at theend of this Module.

SAQ 8.1 (Testing Learning outcomes 8.1)
Explain the economic domain of patients in relation to chronic illnesses

SAQ 8.2 (Testing Learning outcomes 8.2)
Mention the new set of demands that families living with chronic illness confront

SAQ 8.3 (Testing Learning outcomes 8.3)
Discuss one of the factors influencing how families will respond to chronic illness

SAQ 8.4 (Testing Learning outcomes 8.4)
How does 10 to 12 years (preadolescent) age group respond to hospitalization?

SAQ 8.5 (Testing Learning outcomes 8.5)
Explain the termination phase of the nurse-patient relationship

Notes on SAQs for study session 8

SAQ 8.1
Chronic illness is emotionally and financially draining. Due to the incapacitating effects of the illness, patients may find themselves giving up their jobs. The patient's family may also experience loss of income, particularly those family members who have to forfeit their jobs to assist with caregiving activities.

SAQ 8.2

- Financial Stressors and Strains
- Social Demands
- Psychological Demands

SAQ 8.3

Family Life Stage

Families who have a family member with a chronic illness have different needs, strengths, and resources at various points in the family life cycle. In a family with young children, for example, when one of the parental figures is diagnosed with a devastating disease, the impact on child-rearing tasks can be affected in several ways.

SAQ 8.4

10 to 12 years (preadolescent)

It is characterized by disturbance, anger/aggression, change in behavior, mood, personality, somatic symptoms, fear and anxiety and fear of death fear.

SAQ 8.5

Preparation of the termination phase begins at the orientation phase, when the duration and length of the nurse-client relationship was established. The nurse terminates the relationship when the mutually agreed goals are met, the patient is discharged.

The focus of this stage is the growth that has occurred in the client and how the nurse has helped the patient to become independent and responsible in making his own decisions. Client may become anxious and react with increased dependence, hostility and withdrawal; these are normal reactions and are signs of separation anxiety.

These feelings and behavior should be discussed with the client. The nurse should be firm in maintaining professionalism until the end of the relationship. Referral for continuing health care and support after discharge provides additional resources for the client and the family.

References

Cockerham, W. C. (2003). Medical Sociology. (9th edition). NY: Prentice Hall.

Glanz K., Rimer, B.K., & Lewis, F.M. (2002). Health behavior and health education: Theory, research, and practice. San Francisco: Wiley & Sons.

Kinzbrunner, B.M., Weinreb, N.J. & Policzer, J.S. (2002) Common Problems: End of Life Care. McGraw-Hill.

Okun, B. & Nowinski, J. (2011) Saying Goodbye Berkley Publishing Group, Harvard University.

Weiss, L. G. and Lonnquist, L. E. (2005). The Sociology of Health, Healing and Illness, fifth edition, Safari book online. http//www.safarix.com/.