



**Behavioral Medicine  
(psychosocial module)**

## **3. Behavior in clinically difficult situations**

- A. Palliative care
- B. Surgical diseases

## A. Incurable diseases

The diagnosis of incurable disease =  
distress.

It triggers a large array of emotions /  
feelings:

- impotence;
- vulnerability;
- fear;
- sadness;
- depression / hopelessness;
- anxiety;
- social isolation;
- stigmatization.



# The psychological impact of diagnosis

The study of behavioral characteristics of these patients, the psychogenic mechanisms at their origin and the results of the interactions between them highlighted two distinct categories of coping:

- “positive psychological adaptation” – the conviction in the ability to cope with the disease, optimism, desire of confronting with the challenge represented by the disease;
- „negative psychological adaptation“ – resignation, passivity, avoidance, denial, loss of control, or fatality.



# Avoidance in confronting the disease

= incapacity to take decisions;

= giving up the treatment or the monitoring of the disease evolution.

Disease can be seen as a veritable „**death sentence**“, leading to:

- noncompliance;
- insomnia, nightmares;
- food disorders;
- incapacity of directing the thoughts towards constructive actions;
- hopelessness-helplessness.

Rarely, the rejection of the treatment is the consequence of an analysis based on logic and pertinent arguments. More often, this is not the case.

**Socio-demographic factors** which may modulate the attitude of avoidance include:

- low level of education;
- poor socio-economic status;
- financial consequences of the treatment;
- the need to keep secret the diagnosis, deriving from the anticipation of stigma.

# Acceptance of the disease

Represents **the attempt of patients to attribute a sense or scope to the disease;**

In some cases, the patients concentrate not on the sense, but on the **causality of the disease**. Thus, they can defend themselves from the mental pressure created by the presence of the disease, by obtaining information regarding elements such as the cause, the triggers of the disease, the prognosis etc.;

**Acceptance may be beneficial** in some patients:

E.g., if the patient associates the disease with his / her previous lifestyle, acceptance may facilitate various lifestyle changes in the future;

In some other cases, **acceptance may have a negative outcome:**

E.g.1: the patient puts the blame for the occurrence of the disease on other persons  
→ conflicts with other persons, noncompliance;

E.g.2: the patient exaggerates in self-blaming → self-isolation → emotional disorders  
→ noncompliance.

## Psychiatric consequences

The onset of **depression** is easy to understand, given the progressive deterioration of the health status.

In what concerns the origin of **anxiety**, there are a few scenarios:

- fear of interventions and painful, repetitive investigations;
- anticipation of the therapy's side effects;
- incertitude regarding healing.

Sometimes the treatment may lead by itself to **psychiatric comorbidity** (e.g., dysphoric states, maniacal states, confusion, paranoid ideation). A supportive network and a stable social status may prevent the occurrence of these symptoms .

The patient may display a certain **global emotional frailty**.

# The psychological impact on shifting to palliative care

**Palliative care** has the aim to slow the progression of the disease, addressing current symptoms and complications, and maintaining the highest possible quality of life, given the accelerated deterioration in the functioning of the whole organism.

**Passing from the curative to the palliative phase is extremely demanding, from a psychological point of view**, for all individuals involved in the process.

The progress of the emotional states is similar to the one met when finding out the diagnosis (denial, doubt, bargain, resignation), however the feeling of control loss and helplessness is higher. The patient needs to pass abruptly from the problem – centered coping to the emotion – centered coping.

Some patients manage to maintain a certain degree of **control of their emotions**, whereas others **plunge into despair, passivity and demoralization**.

Common psychological reactions are **irritability, nervousness, confusion, lack of concentration, erratic behavior and ideation**.

## Factors that influence behavior in palliative care

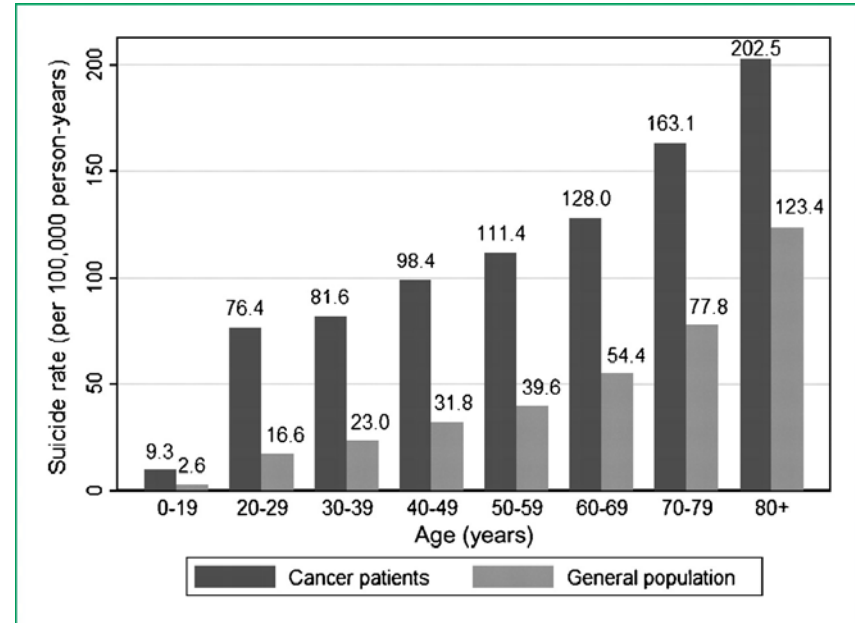
- personality type (e.g., type C);
- history of psychological symptoms (personal, familial, or derived from the therapeutic relationship);
- medical knowledge;
- social roles and familial interactions of the patient;
- social position;
- biological age;
- differences in what concerns self-awareness and the use of own resources (e.g., internal vs. external locus of control);
- adherence to a preformed model of attitude towards illness and death (pertaining to the society, family, or peer groups).





## Risk factors for suicide

- advanced stage of the disease;
- unfavorable prognosis;
- intense pain;
- depression uncontrolled through medication;
- delusion;
- helplessness / loss of personal dignity;
- history of psychiatric illness;
- family history of suicide;
- high fatigue;
- alcohol consumption / smoking;
- social isolation;
- substance abuse.



## Behavior at the end of life

- the patient's attention is directed towards him / herself;
- the patient openly discusses the consequences of own death on the dear ones;
- the thoughts are focused on the imminence of death;
- the patient may concentrate on “unfinished businesses”;
- the desire to discuss about own death;
- the difficulty to separate from the family and the dear ones.



# The role of hope

- represents an important element and can decisively influence the vital prognosis in incurable diseases;
- life expectancy in incurable diseases is correlated to the *concrete* manifestation of hope.

Not all kinds of hope are beneficial. Some incurable patients may for example remain in the so-called “blind hope” zone, despite the medical information which objectively contradicts it. The sources for this type of hope are multiple. The common denominator is that patients have an unlimited and hazardous trust in the possibility of total healing, even they are informed about the negative prognosis of their disease.

Encouraging “blind hope” may have an important role in the deterioration of the Dr-Pt interaction:

- the patient may suspect a lack of professionalism from the Dr;
- the Dr is invested with less credibility → non-compliance.

## Realistic hope

- positively associated to hardiness;
- hardy patients or those endowed with the “will to hope” have a high secretion of endorphins, this leading, through the immune stimulation of the NK cells, to the activation of latent resources of resistance.

### Types of adaptive hope:

- “hope as a closed area” – concentration on the pleasurable sides of life which are still functional;
- “hope as a bridge” (there is a way out from the desperate current situation and a road directing the patient towards a positive future);
- “hope as a durable intention” (positive thinking centered around a positive event in the near future, an event which the patient is determined to experience);
- “hope as a daily performance” (the ability to maintain a daily concentration on living with hope).

# Medical and psychological assistance in Palliative Care (*end-of-life care*)

Critical objectives:

Dignity

Respecting the patient's wishes

Quality of life / death (good death)

# Critical points in the discussion with an incurable patient

- the do-not-resuscitate choice;
- the openness to discuss topics related to:
  - incurability;
  - death;
- perceived social support;
- unmet / unexpressed needs;
- the correspondence basic values – therapeutic options.

## Forms of euthanasia and medically-assisted suicide

Term	Definition	Legal status (USA)
Active euthanasia with consent	Death actively provoked by the doctor at the request or with the informed consent of the patient	Illegal
Active euthanasia without consent	Death actively provoked by the doctor without an explicit request from the patient	Illegal
Passive euthanasia	Death provoked by the doctor, by taking the patient off the machines keeping him/her alive, or through suspending his/her medication	Legal, with the informed consent of the patient
“Double effect”	Administering medicine that relieve patient’s suffering , but at the same time hasten his death	Illegal
Assisted suicide	The doctor provides the patient, at his/her request, with the necessary means to end his/her life	Illegal in most states, but with legalization tendencies

# Modulating variables for the desire of euthanasia and medically – assisted suicide

- presence / absence of family support;
- educational level;
- gender;
- the belief in the utility of religious faith;
- quality of life;
- psychological symptoms (esp. depression);
- the high costs of accessing Palliative Care.





# Therapeutic models in Palliative Care

## The traditional model

Diagnosis phase	Reccurence phase	End-of-life phase
Treatment		
	Treatment of symptoms	Palliative care, the control of main symptoms (e.g., pain)
Simple psychological support (only for the patient)	Psychological support for accepting the prognosis (only for the patient)	

# Alternative models



Diagnosis phase	Recurrence phase	End-of-life phase	Post-death phase
Treatment			
The control of critical symptoms (e.g., pain)			
	Psychological support for the patient		
Psychological support for the family			

Diagnosis phase	Recurrence phase	End-of-life phase	Post-death phase
Treatment			
The control of critical symptoms (e.g., pain)			
Psychological support for the patient			
Psychological support for the family			

## B. Surgical diseases

- “all or nothing”, unequivocal type of care;
- the patient has the perspective of a rapid and definitive healing (this creates the premises for high hopes, and consequently, of high disappointment, when these hopes are not fulfilled: depression, panic, non-compliance);
- is dominated by risks (sometimes major, threatening the integrity and life of the patient);
- the emotional component of care is high.  
While transference in surgery is typically high, countertransference remains low, this leading to a series of unexpressed or unmet patient needs;



- all the development of surgical care is characterized by a possible dramatic scenario, mostly originating in the risk *perceived* by the patient;

- the patient can have emotions of feelings consistent with the idea of „corporal prejudice“;

- the lack of contact time in surgery may allow other health professionals to take part of the care duties, however this may create in some patients feelings of frustration and insecurity. Part of these patients may recourse to rationalization or denial, to handle these feelings.

- sometimes, the cumulative psychological impact of surgery is visible in doctors, too (high risk of burnout).



- losing the connection with the surgeon (typical when doing general anesthesia, but occurring also early after the operation) can be perceived in a different manner, according to the patient's coping style:
  - active coping: the patient is permeable to rational arguments in the pre- / postoperation phase;
  - passive coping: the patient may remain dominated by anxiety. The doctor should use more encouraging messages, centered on providing emotional security.
- the therapeutic relationship is assymmetric, in the sense of a dominant position of the surgeon. This can stimulate investing the surgeon with „mythical“ abilities, and consequently, the patient's expectations.

The notion of compliance can have a different sense – some patients tend to be neglectful in the postoperative phase.



# Anxiety in surgical diseases

- the most frequent psychiatric symptom in surgery;
- occurs both before and after surgery;
- can significantly influence prognosis.

Modulating factors:

- patient's personality type;
- type of intervention;
- quality of therapeutic relationship.

**The emotional security of the patient should represent a therapeutic priority !**

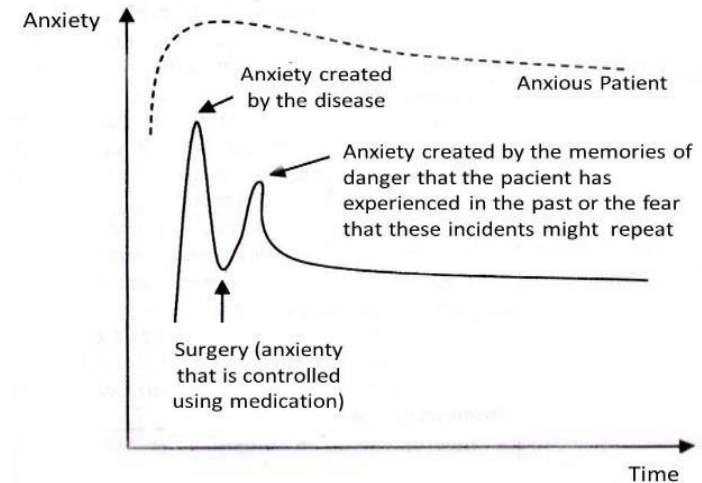


## **Anxiety Management in Adult Day Surgery**

A Nursing Perspective

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- in emergency situations, anxiety, as a rule of thumb, has a higher intensity right before the intervention (the cause being mainly the important expression of the symptom and less the anticipation of surgery). Shortly after operation, the patient may experience a second moment of anxiety, produced by the evoking of the dramatic moments faced and the possibility that they will repeat in the future;
- in programmed surgical interventions, anxiety has a significant preoperative component, with two peaks (one corresponding to the announcement about intervention and the second nearby intervention);
- in esthetic and transplant surgery, anxiety may be higher in the late postoperative period (this representing a high risk of information contagion).



# Depression in surgical diseases

Is relatively frequent, especially in postoperative phases, when it may stem from the failure of the intervention, but also from its irreversible consequences.

The depression with preoperative onset can represent a problem, as it is often correlated to a bad prognosis.

In assessing the seriousness of depression in surgery one must consider:

- the objective context (e.g., the characteristics and prognosis of the disease);
- the subjective context (e.g., the patient's expectations, the patient type, the perceived social support).

Recognizing the predisposing circumstances for depression and its prevention / treatment should represent a priority in surgery, even if the surgeon is not the one required to solve it.

The collaboration between the surgeon and the clinical psychologist is extremely important in the prevention and management of depression in surgery.



# Dr-Pt relationship in emergency surgery

The contact time can be very low, especially in the preoperative phase.

The confrontation with the psychological shock of the relatives, but also with the pressures emerging from them, can be overwhelming for the physician.

The patient and physician anxiety is high, taking into account the specific of the situation (urgent and unpredictable).

The interdisciplinary approach can sometimes bring a supplementary degree of stress (both to the Dr and to the patient).

The burnout risk is increased at physicians who work in these services and may have redoubtable consequences on the way of communication with patients.



## Dr-Pt relationship in esthetic surgery

The physician needs to grow his/her psychological abilities and needs to draw the attention of the patient to the fact that any surgical intervention may have some risks and does not represent an universal solution.

The affective ambivalence of the patient may occur when the physician has not moderate enough the expectations of the patient towards the intervention.

The physicians needs to collaborate with the psychologist / psychiatrist, especially if the patient displays obvious psychiatric symptoms (e.g., dysmorphophobia).

Surgical intervention should be avoided in following circumstances:

- history of psychiatric illness (especially when serious or with frequent relapses);
- the repetitive use of esthetic surgery, followed by discontent;
- the patient is a "surgeon shopper";
- the patient imagines the intervention as an universal solution;
- the patient took the decision under the influence of a momentary impulse or in order to publicly display the results of surgery.

# Dr-Pt relationship in transplant surgery

Anxiety plays a much more important role, both in the preoperative and postoperative phase, consequently the emotional security of the patient becomes a priority.

The maintenance of the contact between the patient and the Dr in the postoperative period can have remarkably positive effects.

## DEPRESSION

- Transplant recipients are at an increased risk of experiencing clinical depression, particularly in the first year after transplant.
- Transplant recipients are also at an increased risk of developing Post Traumatic Stress Disorder.

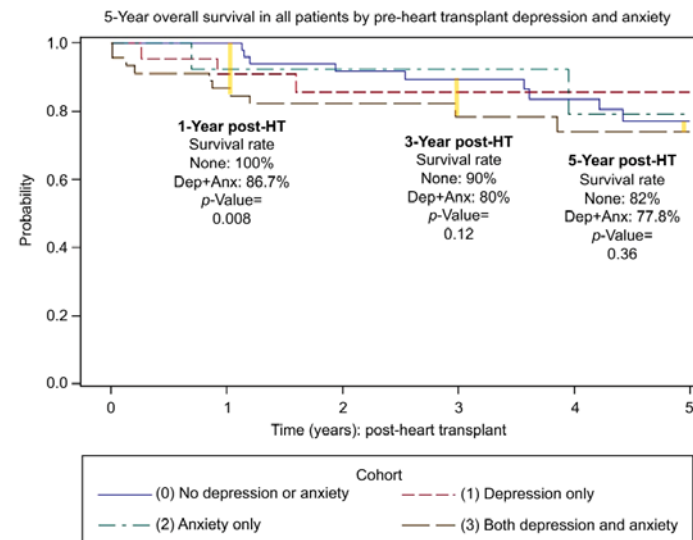


Figure 1 Kaplan-Meier survival analysis: overall survival (years).  
Abbreviations: HT, heart transplant; Dep, depression; Anx, anxiety.

# The optimization of therapeutic communication in surgery

## Before the operation

- formation and consolidation of trust (through a quality history taking and time offered to the patient);
- attention paid to the interpretation of verbal and nonverbal messages given by the patient;
- the growth of the abilities to ask questions designed to explore the patient's emotional state;
- preoccupation for the somatic and psychological symptoms which are relevant in the history of the patient;
- acknowledging and addressing communication barriers;
- taking into consideration the beliefs, values and socio-economic status of the patient, the adaptation of the therapeutic relationship to them;
- giving time to the patient to express or clarify doubts.

## **After the operation**

- maintenance and development of the therapeutic relationship;
- legitimization of the patient's emotional reactions, avoidance of cynical, rude or indifferent attitudes;
- the attempt to offer competent and empathetic solutions to the problems of the patient;
- acknowledging and avoidance of conflict sources;
- admission of own limits and seeking of assistance within the multidisciplinary team.

## **Before and after the operation**

- counseling and negotiation with the patient;
- the attempt to humanize and keep symmetrical the therapeutic relationship;
- nuanced and non-aggressive feedback given to the patient regarding those behaviors that can aggravate suffering;
- considering the patient a partner, and not an object.