Psychological Adjustment in Individuals With Coronary Heart Disease

Yulia Safitri¹, Lely Safrina²

¹ Department of Psychology, Faculty of Medicine, Universitas Syiah Kuala, lely@unsyiah.ac.id
² Department of Psychology, Faculty of Medicine, Universitas Syiah Kuala

Abstract. Psychological adjustment is one of the most important things needed by individuals with chronic disease to have a positive life regardless of the impact caused by their illness. This study aims to determine the dynamics of psychological adjustment in individuals with coronary heart disease (CHD). The method used in this research is phenomenological qualitative approach. Respondents in this research are four people (three men and one woman) who suffered from coronary heart disease. Data were collected through a semi-structured interview, then analyzed by using interpretive analysis technique. The results showed that all respondents had not succeeded in making adjustments to their chronic illness. Three of the four respondents were able to overcome the emotional, cognitive, and physiological effects of chronic disease, but still failed in behavioral aspect especially in terms of lifestyle changes and routine check-up. In contrast, one other respondent showed a negative adjustment on physiological and emotional aspects, but instead had a much more positive adjustment in behavioral aspect because of the high level of compliance in terms of self-management. Factors found to influence psychological adjustment processes in individuals are belief, coping, and family support.

Keywords: chronic disease, coronary heart disease, psychological adjustment.

Introduction

Coronary Heart Disease (CHD) is defined as a disease developed through the buildup of plaque on the coronary artery that reduce and block blood flow consisting of oxygen to heart muscles, which can lead to angina and heart attack (National Heart, Lung, and Blood Institute, 2018). The global mortality rate due to CHD as stated by WHO (2018) reaches 26.7% in 2010, and it is estimated to keep on raising to 27.3% by 2020 and 28% by 2030. WHO (2018) also states that 82% of increasing mortality rate
of CHD is predicted to appear in developing countries. Data from the Institute for Health Metrics and Evaluation [IHME] (2016) mentioned that Ischemic Heart Disease (another name for CHD) is the leading cause of death for all ages and premature death for people under 75 years old in Indonesia in 2005–2016.

CHD, which is commonly suffered by individuals in their middle age and older, can cause physiological, psychological, and economic issues (Karataş & Bostanoğlu, 2017). Patient who suffered from a heart attack tends to suffer from other attacks in the future, although it cannot precisely be predicted (Brannon, Feist, & Updegraff, 2014). CHD that diagnosed after a heart attack, usually occurs suddenly without warning and has the potential to cause death, which makes people suffering from this disease has high emotional stress (Bennett, 2007). Heart attack patients are also reported to experience depression and high anxiety in the first year of diagnosis (Lane, Caroll, Ring, Beevers, & Lip, 2002), and even remain at risk of depression in 2–4 years and 48 years after diagnosis (Polsky, Doshi, Marcus, Oslin, Rothbard, Thomas, & Thomson, 2005).

Ambrocio et al. (2015) state that adult with chronic disease needs five essential things to have a positive life, they are acceptance, coping, self-management, integration, and self-adjustment toward the chronic disease. Adjustment is considered as the main purpose every individual need to achieve when suffering from chronic disease (Sidell, 1997). Adjustment allows patient to reach the optimal balance between himself/herself and the environment, apart from the effects of the disease he/she suffers (Livneh & Antonak, 2005).

Although many people will eventually have good adjustment, some others fail or need longer time to achieve it (de Ridder, Geenen, Kuijer, & van Middendorp, 2008). Individual with successful psychological adjustment to chronic disease can be seen in a few characteristics which are low distress level, minimum effects of chronic disease toward interpersonal relationship, good disease management, and high level of positive affective experience (Moss-Morris, 2013). Successful adjustment also involves lifestyle change and progressive transformation on personality where patient embraces the chronic disease as a part of himself/herself (Ambrocio et al., 2015).

Whereas the unsuccessful psychological adjustment as stated by Moss-Morris (2013) is shown in a few characteristics; interpersonal relationship disruption, bad disease management, low level of positive affective experience, and high level of distress. Sarafino and Smith (2008) also mentioned that someone with chronic disease commonly experiences some problems in adjustment like in physical, social, and emotional aspect, work, self-concept, and adherence to medical treatment. Furthermore, Moss-Morris (2013) explained that the obstacle in adjustment consist of some points; high level of distress felt by patient, negative illness representation, feeling of helplessness, and the wrong the perception that the disease is worse than the actual one (catastrophic).

Various studies have proved that many people do not show the adjustment patterns based on predicted sequences, so the idea that adjustments to chronic disease happens
through particular stages (for instance the one explained by Kübler-Ross) is considered misleading (Wortman & Silver, 2001; Wortman & Boerner, 2011). Although few people suffering from chronic disease shows the adjustment patterns in a predicted order, most people actually show fluctuated emotions and coping patterns (Sarafino & Smith, 2011). Adjustment towards chronic disease itself is unique, personal and hard to define (Sidell, 1997). Adjustment to chronic disease is also very heterogeneous even in individuals who have similarities in terms of gender, illness, stage of disease, and prognosis (Larsen, 2016).

According to Stanton and Revenson (2011), although studies on adjustment to chronic disease has shown progress especially with the conceptualization and operationalization which consist of various dimensions (multifacet), researchers still continue to study how individuals can deal with problems caused by chronic disease. Moss-Morris (2013) argues that although there have been many concepts and theories that explain the adjustment of chronic diseases, there are still inconsistencies, especially in terms of defining or measuring this construct. For this reason, research is still needed in the future with various approaches to understanding adjustment, one of which is qualitative research aims to find out the experience of chronic diseases based on the perspective of individuals who experience them (Stanton & Revenson, 2011). Larsen (2016) also argues that adjustment can only be seen from an individual perspective, because the experience of each individual regarding his/her illness will vary depending on various factors.

**Theoretical review**

**a. Psychological adjustment**

de Ridder, Geenen, Kuijer, and van Middendorp (2008) conclude that psychological adjustment is an attempt done by any individual with chronic disease to balance his/her life when new circumstances occurred due to the disease. Moreover, de Ridder et al. (2008) explain that the efforts individual made in order to balance his/her life cover four aspects which are physical, emotional, behavioral, and cognitive.

Physiologically, patient is expected to maintain an active life that can go well with his/her disease. Maintaining active life can also be done by doing various physical activities or exercise that is adjusted with the severity of the disease. Emotionally, an individual should regulate negative emotions caused by chronic disease, so that he/she has control over his/her life. Individual with the emotion regulation of avoidant and inhibition tends to show adjustment failure, while someone who admits and expresses their feelings well can usually adjust himself/herself well. As in behavioral aspect, someone with a positive psychological adjustment is shown in a good self-management. Disease management by changing lifestyle, adherence toward medication procedure, and other behaviors aim to prevent complications, will help patients to adjust with
his/her chronic disease. Cognitively, illness perception and a cognitive strategy like benefit-finding or posttraumatic-growth can be used by individual to fight the negative effects caused by the disease. De Ridder et al. (2008) state that a person who successfully uses those four strategies has high possibility to adjust well to challenges posed by the chronic disease.

Factors that influence psychological adjustment to chronic disease, as stated by Helgeson and Zajdel (2017) can be classified into two groups which are resilient or resistance factor and risk or vulnerable factor. Resistance factor eases the adjustment, while risk factor can constrain the adjustment process. Resistance factor consists of cognitive adaptation, positive aspects of personality (conscientiousness, optimism, and mindfulness), benefit-finding, and individual’s ability to let go of the goals that cannot be achieved due to the condition of the disease, and then find new goals that are still possible to pursue. Risk factor consists of pessimistic attribution style, unmitigated communion, avoidant coping, and rumination.

\textbf{b. Coronary Heart Disease (CHD)}

Brannon, Feist, and Updegraff (2014) state that Coronary Heart Disease is a disruption caused by myocardium breakdown because of insufficient blood-supply. Brannon, Feist, and Updegraff (2014) also mention that Coronary Heart Disease is one of the cardiovascular diseases consisting of few risk factors which are inherent factor (unchangeable), physiological condition factor, behavioral factor, and psychosocial factor. First, inherent risk factor consists of age, family history, gender, and ethnicity background. Next the physiological condition factor consists of hypertension, cholesterol level, glucose metabolism issues, and inflammation. Behavioral factors that can cause CHD are smoking, obesity, unhealthy diet, and being not physically active. Last, psychosocial factor consists of low level of income rate and education, low social support and marriage quality, hostility and anger, Cardiovascular Reactivity (CVR), suppressed anger, stress, anxiety, and depression.

\textbf{Research method}

This research was conducted by using qualitative method with phenomenology approach. The sampling procedure was conducted by using purposive sampling technique where respondents were chosen based on certain criteria. The characteristics in choosing the respondents are (a) suffered from any condition of Coronary Heart Disease (CHD); and (b) willing to be involved in this research. Respondents involved in this research were four people who are later called R1, R2, R3, and R4. The data collection was done through a semi-structured interview, and then being analyzed by using interpretive analysis technique.
Table 1

*General Overview of the Respondents*

| Dimension          | Respondent 1     | Respondent 2     | Respondent 3     | Respondent 4     |
|--------------------|------------------|------------------|------------------|------------------|
| Age                | 55 years old     | 51 years old     | 50 years old     | 56 years old     |
| Sex                | Male             | Female           | Male             | Male             |
| Religion           | Islam            | Islam            | Islam            | Islam            |
| Ethnicity          | Acehnese         | Acehnese         | Acehnese         | Javanese         |
| Education          | Senior High School | Bachelor Degree | Bachelor Degree | Junior High School |
| Occupation         | Private Employee | Private Employee | Private Employee | Private Employee |
| Address            | Banda Aceh       | Banda Aceh       | Banda Aceh       | Banda Aceh       |
| Year of being diagnosed | 2016         | 2016             | 2015/2016        | 2016             |

**Result**

Result analysis was conducted by grouping the common experiences of the four respondents in themes. Theme grouping was done relying on psychological adjustment aspects by de Ridder et al. (2008) as shown below:

**Aspect 1: Physiological**

**Theme 1: Maintaining active life**

Reviewing from the ability to maintain activities, three respondents, R1, R2, and R3, still do their activities the same way before they were diagnosed. However, the other respondent (R4) reduce his activities because he feels demotivated to do even daily activities he usually does. Demotivation is not the only reason, R4 is afraid that his condition will gets worse if he still does his common routine.

**Aspect 2: Emotional**

**Theme 1: The ability to overcome negative emotion**

Three respondents who are R1, R2, and R3, were able to handle the negative emotion they feel. R3 didn’t feel negative emotion except shock when diagnosed with CHD, and it didn’t last for a long time because he admitted that CHD didn’t affect him that much. R1 only felt negative emotions during hospitalization that lasted for 16 days, when he was being treated for the first time because of heart attack. After being discharged from hospital, R1 admitted that he could overcome his negative emotions already. According to R1, he didn’t experience negative emotion in the long term because of two reasons. First, this respondent strongly believes that life is God’s provision. Another reason is the fact that his physical condition got positive improvement after being diagnosed and undergoing treatment. For R2, the negative emotions were more intense and last longer. She had an excessive fear of death and it got to the point where she felt that she couldn’t
survive and has prepared herself to die. R2 overcame her negative emotions after three months by getting closer to God by doing more worshipping. She also emphasized the role of her family support in those difficult times which helped her to feel better.

When those three respondents could overcome their negative emotions, R4 could not. R4 admitted that he has done some strategies to avoid anxiety and negative thoughts by reciting istighfar more often, surrendering to Allah, and asking for support from friends. These efforts only managed to divert the negative emotions experienced by R4 for a while, but couldn’t completely eliminate them because it often reappeared suddenly at certain times.

**Aspect 3: Behavior**

**Theme 1: Medicine consumption**

Three out of four respondents who are R1, R3, and R4, consume their medicine routinely. Those three respondents were aware that consuming medicine is important to control their health condition. However, R2 is not like the other three respondents. R2 only consumed the medicine a few months after being diagnosed and then stopped. R2 argues that the belief of relying your health condition on consuming medicine is a form of betraying God (infidelity) because it means someone puts his/her hopes to be healthy on other things but Allah.

Another reason why R2 stopped consuming medicine is her concern that the side effects of consuming medicine for a long time would affect complication. R2 also believes that each disease that she suffered consecutively (asthma, diabetes, hypertension, and then CHD) is due to the medicine she consumed for the previous disease.

**Theme 2: Lifestyle change**

**Sub-theme 1: Diet**

Two respondents who are R2 and R4 keep on their diet because they think that it is important to control their health condition and to prevent worse complications. Two other respondents who are R1 and R3 didn’t change their diet by still consuming unhealthy food for their heart. Both respondents admitted that they got warned by medical workers about some types of food that’s not beneficial for their heart condition, but they didn’t make any effort to stop consuming it. One respondent, R1, also has another reason to avoid healthy diet. He thought that human living-time is God’s absolute provision, so he didn’t need to constrain himself with strict diet.

**Sub-theme 2: Smoking**

Apart from R2 who do not smoke, the other three respondents, R1, R3, and R4 admitted that they started smoking since they were young. R3 stopped smoking before he was diagnosed with CHD, because he suffered from another disease before that. R4 stopped smoking after being diagnosed with CHD because he realized the detrimental effects of smoking that can worsen the disease. However, R1 is not like other respondents; he still smokes even after he was diagnosed with CHD. As what R1 mentioned,
age is God’s absolute provision, so smoking cannot be a reason for someone to die. R1 also emphasizes his opinion by saying that even his own cardiologist is a smoker.

Sub-theme 3: Exercise

This study reveals that all respondents didn’t do any exercise at all after they were diagnosed with CHD. Few respondents admitted that the medical workers had advised them to do exercise, but they didn’t do it anyway. Their reasons are; they do not used to do exercise since young age; they didn’t have time to do it; and that there are more important things to do than exercising.

Sub-theme 4: Routine Check-up

The result of this study shows that only R4 is adhering to the routine schedule for checking up to the doctor or hospital, however the other three respondents were not. These three respondents didn’t consistently do their checkup or even skip the routine checkup at all. R1 confessed that he often missed the scheduled checkup deliberately, while R3 said that he only visited the hospital when he felt the symptoms. R2 however, stopped the medical treatment at all because she didn’t feel the symptoms anymore, so she thought that she was already recovered. Nevertheless, R2 couldn’t show the proof that supports her belief.

Aspect 4: Cognitive

Theme 1: Perception of the disease

Four respondents have different views about CHD. R1 considered CHD as a common disease that should not be worried about so much. However, R2 and R3 thought of CHD as a form of God’s will and trial which has to be accepted and lived by. All three respondents had the tendency of more positive illness perception when compared to R4, who considered CHD as a “deathly” disease so that he feared on his future for being affected by this disease. R4’s opinion was influenced by the conclusion he drew out of his doctor explanation and his experience of seeing numerous people around him who died suddenly due to heart disease.

Theme 2: Benefit-finding

Out of four respondents, R3 is the only respondent who thought that this disease has no positive effect whatsoever. Three respondents thought that there are still certain positive effects out of the diseases they suffer from. R1 said that the positive effect is that he can use his experience in dealing with CHD to support other people who suffered from the same disease like him. R2 also admitted that her disease significantly affects her life in a positive way. R2 felt that she had become a better person especially in worshipping God, maintaining a heathy diet, and better emotion regulation. For R4, the positive effect of CHD is that the disease allows him to stop smoking willingly because he has finally realized that smoking is bad for health.
Discussion

Based on the research result, all four respondents show different psychological adjustment pattern. In general, all respondents show the pattern where at certain aspects the adjustments are positive, but at another aspect it’s negative. This proves the previous research findings in the literature that psychological adjustment to chronic disease involves both positive and negative aspects (Stanton, Revenson, & Tennen, 2007; Stanton & Revenson, 2011; Larsen & Hummel, 2013; Larsen, Hummel, & Osuji, 2014). This possibly happens because positive and negative indicators of the adjustment to chronic disease consist of different determining factors and also have different consequences (Stanton, Revenson, & Tennen, 2007; Stanton & Revenson, 2011).

Positive adjustment is dominantly shown on emotional, cognitive, and physiological aspects. Most of the respondent’s show that negative emotions occurred from chronic disease can be overcome. This might happen because of the duration of an individual’s disease or time since being diagnosed. As Stanton and Revenson (2011) have concluded that the highest level of distress and disruption felt by patients with chronic disease is in their first year after diagnosed or at the beginning of medication process, and then it will be eventually better. All respondents in this study have been diagnosed for two years, and this probably explains why most of them have a positive pattern in the emotional aspect.

The majority of respondents who showed positive emotional adjustment also have the same pattern in cognitive aspect. Hirani and Newman (2005) reveal that individual cognition about illness and its treatment efforts have a relationship with emotional states. One of the reason why it could happen is because depressive individuals tend to be more susceptible to receiving negative information about their disease or threats to their condition, so they have negative cognitive biases related to the disease (Sharpe & Curran, 2006). Dijkstra, Buunk, Tóth, and Jager (2008) also state a similar opinion that someone with a positive perception about the disease is commonly someone with low and insignificant negative emotion.

From the physiological aspect, as in maintaining daily activities, almost all respondents show positive adjustment. This is in line with the finding of research done by Tomich and Helgeson (2002) that there is no difference between someone with chronic disease and someone with no chronic disease on the physiological function that affects daily activities. Specifically to CHD, this condition happened because medication helps in controlling and reducing disruptions related to CHD itself (Wahyudi, 2016). This causes individuals to experience an increase in physical condition which then facilitates daily activities and make it easier (Wahyudi, 2016).

As in emotional, cognitive, and physiological dimension, respondents showed a tendency of positive adjustment, but not in behavioral aspect. Majority of respondents are found as having negative adjustment in behavioral aspect, except for the medicine
consuming. Almost all respondents are not adhering to the responsibility to change their lifestyle and have routine checkup. According to Brannon, Feist and Updegraff (2014), adherence is generally a major issue in the rehabilitation effort of CHD patients.

In this research, respondent belief about the disease found to be the factor influences self-management behavior that constrains adjustment. The respondent belief, which is based on religious teaching, affects the respondents in both negative and positive way. Respondents have a strong belief about God’s provision, and they consider the disease as a trial and fate from God to be accepted and live by. This belief affects most of the respondents positively because they tend to have a positive perception about the disease, and it also helps respondents in overcoming their negative emotions. Besides the positive effects, the misleading understanding of religious teaching also had a negative impact because it caused some respondents to ignore disease management behavior. Two respondents, specifically R1 and R2, were found to have certain beliefs about the disease that based on their understanding of religious teachings. R1 didn’t do healthy diet and kept smoking because of the belief that life and death is only determined by God, so smoking or unhealthy food cannot be used as a reason for someone’s death. R2 was also found to have the belief that the consumption of medicine can trigger other diseases and is considered a practice of betraying God (infidelity) or shirk behavior. Thus, R2 stopped consuming medicine although medical workers suggest otherwise. This shows that individuals find it difficult to implement recommendations related to disease management when they have their own beliefs about the disease and efforts to control it.

Park and Folkman (1997) explained that religious belief is something stable, means that it is more likely for someone to change his/her perception about something to fit the religious belief, rather than to change the religious belief itself. Padela and Zaidi (2018) also explained that religious practices (like praying, reciting Al-Qur’an, and begging God) contains therapeutic effects both physically and psychologically, but it can also constraint helpful behavior, especially in medical care. This happens because religious practices are often seen as the main step to overcoming disease, which then makes patients assume that conventional treatment is not needed (Padela & Zaidi, 2018).

Moreover, R1 also stated that his cardiologist is a smoker himself. R1 said that this fact even strengthens his belief that smoking cigarettes have no negative effects on the disease, because medical workers should know better about smoking. Brannon, Feist, and Updegraff (2014) revealed that apart from the patient, there is also another factor influencing the adherence in disease management that involves the medical workers. Abu-Baker, Haddad, and Mayyas (2010) explained that the percentage of CHD patients who are still smoking in developing countries (with low or below average category of income) is actually higher when compared to the developed countries. Furthermore, Abu-Baker, Haddad, and Mayyas (2010) emphasizes that this is due to the cultural differences where smoking is still commonly accepted in social life, especially
for male, and even when it’s done in a public area like a hospital either by the patient, client, or even medical workers.

Another interesting finding in this research is the adjustment patterns where three respondents showed positive adjustment in physiological, emotional, and cognitive aspect, but also had negative adjustment in the behavioral aspect. In contrary, one respondent (R4) who has trouble in adjusting to his chronic disease especially in emotional and physiological aspects, show better adjustment in behavior compared to the other three respondents. R4 perceives his disease as a serious medical issue by considering CHD as a deathly and risky disease that can lead to sudden death. This makes him to actually have high adherence in managing the disease by doing things like stop smoking, having routine consumption of medicine, having a strict diet, and having a routinely scheduled control to the hospital. Hampson, Glasgow, and Zeiss (1994) found that the more serious individual perceives his/her disease, the higher possibility for that individual to be involved in the treatment process and engage in self-management behavior. This is also in line with the theory of Health Belief Model (HBM) that explains one out of six things that lead to healthy behavior is someone’s belief about the severity of the medical issues he/she experiences (Gurung, 2013).

Moreover, Hirani and Newman (2005) also found that when someone considers his/her disease is caused by un-avoidance external factor (for example genetic abnormalities, hereditary), it lets the person to involve in behavior that affects negatively on health. In contrary, when someone belief that the disease is due to his/her lifestyle, that person will have a high willingness to maintain or change their lifestyle (Hirani & Newman, 2005). This idea is in line with respondents’ behavior pattern in this study. R4 realized it that his behavior before being diagnosed is one of the factors of why he suffered from the disease. If he keeps these behaviors, then he believes it will worsen his condition. R4 turned out to be more adherences on medical workers suggestion related to changing lifestyle and having routine control. Different condition is shown by the other three respondents who emphasize more on external factor as the cause of the disease. They also believe that external factors are the one that determine whether their condition gets better or worse. R1 and R2 thought that God is the only absolute factor to determine someone’s condition without looking at his/her own behavior. R3 also believes that physiologically his disease is caused by genetic abnormalities of the hereditary factor. In contrast to R4, these three respondents are shown to have negative adjustment on behavioral aspect by neglecting the self-management behavior except consuming medicine.

Apart from the belief, other things found to be the factors that affect psychological adjustment are coping and family support. Some coping strategies conducted by respondents as the efforts to overcome the effects of the chronic disease, which are doing more religious practices, getting close to God, and sharing story and hanging out with friends. According to Taylor and Stanton (2007), coping process is one of...
contributors in adjustment that makes coping as an important thing. Stanton, Revenson, and Tennlen (2007) state that generally there are two types of coping done to deal with chronic disease, they are active coping or approach-oriented coping (like collecting information, finding social support, and etc.), and avoidance coping (like denial). Furthermore, Stanton, Revenson, and Tennlen (2007) mentioned that another coping effort like spiritual coping can be categorized as both active and avoidance coping. Various coping strategies tend to mediate the correlation between personal and contextual attributes with the adjustment. It also affects other factors in influencing adjustment (Stanton & Revenson, 2011).

Last, all four respondents emphasize that the role of family especially their partner and children in supporting them to face their illness. This is in line with what Hegelson and Zajdel (2017) mentioned that family commonly becomes the source of social support especially for someone with chronic disease. According to Stanton, Revenson, and Tennlen (2007), most adaptive tasks for chronic illness requires help from others, so patients need an available network of interpersonal relationships that can provide emotional support and practical assistance in the face of illness, disability, and uncertainty.

During the process, there were some limitations in this study. The number of respondents who took part in this research is small. Moreover, the duration of data collection is relatively short. This means that maybe there are things and points that can be examined more. Data collection techniques in this study only use interviews, without any additional methods such as observation or re-examination of data sources by collecting documents and interviewing other individuals who knew the experiences of respondents. Last, the respondent dominance is imbalance where there are three male respondents and just one female respondent. It’s suggested that further research on the same topic should have more respondents and a balanced number of male and female. Triangulation in collecting data is highly recommended to improve the validity of qualitative research.

**Conclusion and suggestion**

The research result shows that there is no respondent that meets all psychological adjustment aspects criteria, so it can be concluded that respondents didn’t succeed in adjusting to the chronic disease. The majority of respondents show positive adjustment pattern on emotional, cognitive, and physiological aspects. Most respondents are still able to carry out daily activities the same way before diagnosis. All patients also experience negative emotions to some extent, but most of them can overcome this. There are various coping strategies used by respondents to overcome the emotional impact of CHD, mainly by practicing worship and with strong belief in God’s provision. It also makes them have a more positive outlook on the disease. Unfortunately, as found by Ononeze, Murphy, MacFarlene, Byrne, and Bradley (2009), patients are still skeptical.
about the impact of lifestyle changes on the development of their health conditions. Almost all patients ignore the medical workers’ advice regarding healthy diet, exercise, smoking, or the responsibility to do routine control. One of the main reasons that hinders respondent’s self-management behavior is misinterpretation of religious teachings. Therefore it is suggested for healthcare providers to include religious elements that support treatment, especially for Muslim patients, so there will be no doubt in them to engage in disease management behaviors.

One respondent shows the paradox adjustment pattern which is emotionally and physiologically negative, but positive in behavioral aspect especially in self-management. This respondent has negative perception about the disease, but this led to better adherence to medical treatment and lifestyle changes. He also hasn’t been able to overcome negative emotions, although he has done various strategies to avoid anxiety and negative thoughts. Lazarus and Folkman (1984) indeed revealed that sometimes individuals use avoidance as coping strategies, where it aims to control their emotional responses to stressors. But according to Petrie and Reynolds (2007), coping strategies that focus on emotions, such as moving away from situations that can cause negative emotions or avoid thinking about illness, are generally found to be associated with increased distress. So de Ridder et al. (2008) concluded that it would be more beneficial for patients to regulate their negative emotions by acknowledging and expressing them, as long as those emotions are being processed. As stated by all respondents that family plays significant role in helping them cope with illness, it’s important for families or the closest people of patients to provide the assistance they need, including emotional support, information and advice, as well as providing them with instrumental support (concrete assistance) when it’s necessary. Further research could explore more about the factors that support and inhibit psychological adjustment in patients with coronary heart disease or other chronic diseases.

Reference

Ambrosio, L., Garcia, J. M., Fernandez, M. R., Bravo, S. A., Ayesa, S. D., Sesma, M. E., ..., Portillo, M. C. (2015). Living with chronic illness in adults: A concept analysis. *Journal of Clinical Nursing*, 24, 2357–2367.

Benneth, P. (2007). Coronary heart disease: impact. In S. Ayers, A. Baum, C. McManus, S. Newman, K. Wallston, J. Weinman, & R. West, *Cambridge Handbook of Psychology, Health and Medicine*. UK: Cambridge University Press.

Bishop, M. (2012). Quality of life and psychosocial adaptation to chronic illness and acquired disability: a conceptual and theoretical synthesis. In I. Marini, & M. A. Stebnicki, *The Psychological and Social Impact of Illness and Disability* (6th ed., pp. 179–191). USA: Springer.

Branon, L., Feist, J., & Updegraff, J. A. (2014). *Health Psychology: an Introduction to Behavior and Health* (8th ed.). Wadsworth: Cengage.

Calhoun, L. G., & Tedeschi, R. G. (1999). *Facilitating Posttraumatic Growth: A Clinician's Guide*. USA: Lawrence Erlbaum Associates.
De Ridder, D., Geenen, R., Kuijer, R., & van Middendorp, H. (2008). Psychological adjustment to chronic disease. *Lancet, 372*, 246–255.

Dijkstra, A., Buunk, A. P., Töth, G., & Jager, N. (2008). Psychological adjustment to chronic illness: the role of prototype evaluation in acceptance of illness. *Journal of Applied Biobehavioral Research, 12*(3–4), 119–140.

Festinger, L. (1954). A theory of social comparison processes. *Human Relations, 7*, 183–201.

Gurung, R. A. R. (2013). *Health Psychology: A Cultural Approach*. Wadsworth: Cengage Learning.

Hampson, S. E., Glasgow, R. E., & Zeiss, A. M. (1994). Personal models of osteoarthritis and their relation to self-management activities and quality of life. *Journal of Behavioral Medicine, 17*(2), 143–158.

Hirani, S. P., & Newman, S. P. (2005). General cardiology: patients’ belief about their cardiovascular disease. *Heart, 91*, 1235–1239.

Helgeson, V. S., & Zajdel, M. (2017). Adjusting to chronic health conditions. *Annual Review of Psychology, 68*, 545–571.

Institute for Health Metrics and Evaluation. (2016). *Indonesia*. Retrieved March 19, 2018 from http://www.healthdata.org/indonesia.

Karatas, T., & Bostanoğlu, H. (2017). Perceived social support and psychosocial adjustment in patients with coronary heart disease. *International Journal of Nursing Practice, 23*(4), 1–7.

Lane, D., Carroll, D., Ring, C., Beevers, D. G., & Lip, G. Y. (2002). The prevalence and persistence of depression and anxiety following myocardial infarction. *British Journal of Health Psychology, 7*, 11–21.

Larsen, P. D. (2016). *Lubkin’s Chronic Illness* (9th ed.). Burlington: Jones & Bartlett Learning.

Larsen, P. D., & Hummel, F. I. (2013). Adaptation. In I. M. Lubkin, & P. D. Larsen, *Chronic Illness: Impact and Intervention*. Burlington, MA: Jones and Bartlett Learning.

Larsen, P. D., Hummel, F. I., & Osuji, J. C. (2014). Adaptation. In M. L. Kramer-Kille, & J. C. Osuji, *Chronic Illness in Canada: Impact and Intervention*. Burlington, MA: Jones and Bartlett Learning.

Lazarus, R. S., & Folkman, S. (1984). *Stress, Appraisal, and Coping*. New York: Springer Publishing Company.

Leventhal, H., Benyamini, Y., & Shafer, C. (2007). Lay Beliefs About Health and Illness. In S. Ayers, A. Baum, C. McManus, S. Newman, K. Wallston, J. Weinman, & R. West, *Cambridge Handbook of Psychology, Health and Medicine* (2nd ed.). UK: Cambridge University Press.

Leventhal, H., Brissette, I., & Leventhal, E. A. (2003). The common sense model of self-regulation of health and illness. In L. D. Cameron & H. Leventhal (Eds.), *In The Self-regulation of Health and Illness Behaviour* (pp. 42–61). London: Routledge Taylor & Francis Group.

Livneh, H., & Antonak, R. F. (2005). Psychosocial adaption to chronic illness and disability: A primer for counselors. *Journal of Counselling & Development, 83*(1), 12–20.

Moss-Morris, R. (2013). Adjusting to chronic illness: Time for a unified theory. *British Journal of Health Psychology, 18*, 681–686.

National Heart, Lung, and Blood Institute. (2018). *Coronary Heart Disease*. Retrieved March 26, 2018 from https://www.nhlbi.nih.gov/health-topics/coronary-heart-disease.

Ononeze, V., Murphy, A. W., MacFarlane, A., Byrne, M., & Bradley, C. (2009). Expanding the value of qualitative theories of illness experience in clinical practice: a grounded theory of secondary heart disease prevention. *Health Education Research, 24*(3), 357–368.
Padela, A. I., & Zaidi, D. (2018). The islamic tradition and health inequities: A preliminary conceptual model based on a systematic literature review of Muslim health-care disparities. *Avicenna Journal of Medicine*, 8(1), 1–13.

Park, C. L., & Folkman, S. (1997). Meaning in the context of stress and coping. *Review of General Psychology*, 1(2), 115–144.

Petrie, K. J., & Reynolds, L. (2007). Coping with chronic illness. In S. Ayers, A. Baum, C. McManus, S. Newman, K. Wallston, J. Weinman, & R. West, *Cambridge Handbook of Psychology, Health and Medicine* (2nd ed.). UK: Cambride University Press.

Polsky, D., Dosh, J. A., Marcus, S., Oslin, D., Rothbard, A., Thomas, N., & Thompson, C. L. (2005). Long-term risk for depressive symptoms after a medical diagnosis. *Arch Intern Med*, 165, 1260–1266.

Sarafino, E. P., & Smith, T. W. (2011). *Health Psychology: Biopsychosocial Interactions* (7th ed.). USA: Wiley.

Schneider, A. A. (1960). *Personal Adjustment and Mental Health*. New York: Holt, Rinehart and Winston.

Sharpe, L., & Curran, L. (2006). Understanding the process of adjustment to illness. *Social Science and Medicine*, 62(5), 1153–1166.

Sidell, NL. (1997). Adult adjustment to chronic illness: a review of the literature. *Health & Social Work*, 22(1), 5–11.

Stanton, A. L., Collins, C. A., & Sworowski, L. A. (2001). Adjustment to Chronic Illness: Theory and Research. In A. Baum, T. A. Revenson, & J. E. Singer, *Handbook of Health Psychology*. New Jersey: Lawrence Erlbaum Associates.

Stanton, A. L., Revenson, T. A., & Tennen, H. (2007). Health psychology: Psychological adjustment to chronic disease. *Annual Review of Psychology*, 58, 565–592.

Stanton, A. L., & Revenson, T. A. (2011). Adjustment to chronic disease: progress and promise in research. In H. S. Friedman (Ed.), *The Oxford Handbook of Health Psychology*. USA: Oxford University Press.

Taylor, S. E., & Stanton, A. L. (2007). Coping Resources, Coping Processes, and Mental Health. *The Annual Review of Clinical Psychology*, 3, 377–401.

Tomich, P. L., & Helgeson, V. S. (2002). Five years later: a cross-sectional comparison of breast cancer survivor with healthy women. *Psychooncology*, 11(2), 154–169.

Wahyudi, Y. D. J. (2016). *Studi komparasi activities of daily living pasca perawatan pada pasien jantung berdasarkan jenis penyakit di RS PKU Muhamadithah Yogyakarta*. (Skripsi Dippublikasikan). Universitas Aisyiyah, Yogyakarta, Indonesia.

World Health Organization. (2018). *The Future of CVD*. Retrieved March 26, 2018 from http://www.who.int/cardiovascular_diseases/en/cvd_atlas_25_future.pdf.

Wortman, C. B., & Boerner, K. (2011). Beyond the myths of coping with loss: prevailing assumptions versus scientific evidence. In H. S. Friedman, *The Oxford Handbook of Health Psychology*. New York: Oxford University Press.

Wortman, C. B., & Silver, R. C. (2001). The myths of coping with loss revisited. In M. S. Stroebe, R. O. Hanssson, W. Stroebe, & H. Schut (Eds.), *Handbook of Bereavement Research: Consequences, Coping, and Care*. Washington, DC: American Psychological Association.
Asmenų, sergančių koronarine širdies liga, psichologinis prisitaikymas

Julija Safitri¹, Lely Safrina²

¹Medicinos fakulteto Psichologijos katedra, Syiah Kuala universitetas, Indonezija, lely@unsyiah.ac.id
²Medicinos fakulteto Psichologijos katedra, Syiah Kuala universitetas, Indonezija

Santrauka

Psichologinis prisitaikymas yra vienas iš svarbiausių siekių, būtinų lėtinėmis ligomis sergantiems asmenims, norintiems gyventi pozityviai, neatsižvelgiant į ligų keliamą poveikį. Šiuo tyrimu siekiama nustatyti koronarine širdies liga sergančių asmenų psichologinio prisitaikymo dinamiką. Tyrime naudojamas fenomenologinis kokybinis požiūris. Šio tyrimo respondentai yra keturi žmonės (trys vyrai ir viena moteris), kurie sirgo koronarine širdies liga. Duomenys buvo renkami pusiau struktūruoto interviu būdu, po to analizuojami pasitelkiant interpretacinės analizės metodiką. Rezultatai parodė, kad visiems respondentams nepavyko koreguoti lėtinės ligos. Trys iš keturių respondentų sugebėjo įveikti emocinį, kognityvinį ir fiziologinį lėtinės ligų poveikį, tačiau jie nepavyko keisti įprasto gyvenimo būdo. O vienas respondentas, priešingai, parodė negebėjimą prisitaikyti fiziologiniu ir emociniu aspektu, tačiau elgsena buvo teigiamai koreguojama dėl aukštų savitvarkos reikalavimų. Nustatyti faktoriai, turintys įtakos individų psichologinio prisitaikymo procesams.

Esminiai žodžiai: lėtine liga, koronarinė širdies liga, psichologinis prisitaikymas.

Gauta 2020 05 16 / Received 16 05 2020
Priimta 2020 07 31 / Accepted 31 07 11 2020