

## **Living with Chronic Illnesses and Disability**

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### **Abstract**

*This study extends research on living with chronic illness and acquired disability by examining how psychosocial adaptation processes are changed and which elements are influenced during this process. The first outlines describe some general features and definitions of social adaptation and other relevant criteria on the base of our study. Secondly this paper tries to highlights some recent empirical studies of chronic illness to illustrate some of main stages. Which include: Theoretical background to the concepts of acceptance and denial to chronic illness Challenges to the relevance of acceptance and denial and alternative interpretations of illness experience. This paper argues that psychosocial approach needs to recognize the positive actions people take as well as the problems they face because of their chronic illness.*

**Keywords:** Chronic illnesses. Disability. Psychosocial adaptation. Acceptance. Denial

### **Introduction**

Individuals, who obtain a chronic illness or disability, face a variety of major and overwhelming challenges. Among these is coping with the intransience of the condition and its effects. Life, that gorgeous quality of life, is not accomplished by following another man's rules. It is true we have the same hungers and same thirsts, but they are for different things and in different ways with different seasons." (Patri, as quoted in Nasar, 1998). In contrast to people with cognitional disabilities, for whom research suggests that the process of body image and identity development is likely to be similar to that of children without disabilities (Grzesiak & Hicok, 1994; Livneh & Antonak, 1997; Wright, 1983), people who experience later-onset permanent illness or acquired disability may find their sense of self suddenly and significantly challenged or altered. These people may be faced with significant changes in their social and recognizable relationships and life roles while dealing at the same time as with psychosocial distress, physical pain, prolonged medical treatment, and gradually increasing interference with or restriction of the performance of daily activities.

### **Defining Psychosocial Adaptation**

There are many different ideas regarding the nature of psychosocial adaptation (Livneh, 2001; Livneh & Antonak, 1997; Wright & Kirby, 1999), at a essential stage of adaptation may be imagined as a process of responding to the operative, psychological, and social changes that may happen with the onset and experience of living with a disability, chronic illness, or associated treatments. The whole procedure can be characterized in terms of movement toward some variously described outcome.

Researchers tried to define the process and the outcome in a variety of ways (e.g., DeLoach & Greer, 1981; Kendall & Buys, 1998; Linkowski, 1971; Livneh & Antonak, 1997; Wright, 1983; Wright & Kirby, 1999). The quality of life represents an appropriate framework for defining and understanding the adaptation process; the current idea can say it would be interesting to understand how adaptation process has been conceptualized to date. With current reviews and searching in literatures and historical approaches having important role in the rehabilitation literature, limitations have also been associated with these approaches, and some points of theoretical consensus.

### **Adaptation defined**

The individual's personal and highly individual response to disability or illness-related disruptions across a wide range of life domains. These disruptions may be experienced, for example in interpersonal relationships, in interaction with the physical environment, and as changes in psychological or emotional health and function (Marini & Stebnicki, 2012).

### **Quality of Life Defined**

QOL has been defined in numerous ways and applied in a variety of contexts; it is incumbent on researchers to identify the specific definition for their purposes. Quality of life has been defined in terms of both subjective and objective indices. Usually, researchers more explained about the objective indicators. These include such outwardly manifested and measurable indices as employment status, income, and socioeconomic status (Marini & Stebnicki, 2012).

### **Religious Coping and Spiritual Well-Being**

Nowadays researchers use religious conviction and holiness to better understand mental and physical health in the population (Powell, Shahabi, & Thoresen, 2003). Ellison (1983) suggested that spiritual well-being has both a religious and a psychosocial part. On the other hand, there is a sense of comfort in connecting with God as well as an empirical understanding of life purpose and quality of life. An individual with an acute spinal cord injury may, at the onset, ask what the unexpected accident means to himself or herself. Whether the event is interpreted as a threat or a chance for personal growth depends on the individual's existential plan. In the next stage of the coping process, the individual prays to God to be restored to his or her pre-morbid health. People with a disability may have difficulty explaining why one is selected to become the victim of tragedy while another is not. The coping function of religion may allow some people who are facing a difficult situation not only to make sense of it but also to regulate their emotion in order to facilitate successful coping and adjustment.

### **Hope**

The role of hopeful thinking has been a cognitive construct frequently used by researchers to examine ways of coping with health-related medical conditions, for example burn injuries (Barnum, Snyder, Rapoff, Mani, & Thompson, 1998), spinal cord injuries (Elliott, Witty, Herrick, & Hoffman, 1991), cancer (Irving, Snyder, & Crowson, 1998), and visual impairment (Jackson, Taylor, Palmatier, Elliot, & Elliot, 1998). The central element of hope is the positive expectancy of reaching goals that are deemed achievable to the individuals (Snyder, Lehman, Kluck, & Monsson, 2006). In other words, positive thinking requires the perceived power to imagine possible ways to accomplish predetermined objectives, and is sustained by will power. The question of whether optimism in the disability population might lead to the development of faulty expectancies for full restoration to the premorbid state has drawn interest from researchers.

### **Employment Status**

It is well documented that the salary levels of persons with chronic illnesses or disabilities in both the United States and overseas are below those of the general population (Australian Bureau of Statistics, 2007; Singapore Department of Statistics, 2006; Thai National Statistical Office, 2006; U. S. Census Bureau, 2007). In total population to the severity of the disability, there are adverse impacts on the employment outcomes of people with such a problem (Hill, Tiersky, Scavalla, Laviertes, & Natelson, 1999). In a longitudinal study of individuals with chronic fatigue syndrome, Tiersky and her colleagues (2001) found that 68% of the patients still remained unemployed due to functional disability four years after the initial diagnosis. The emotional influence of unemployment is a significant psychological stressor in people with disabilities.

The connection between unemployment and psychological distress has been evidenced by several studies (Fifield, Reinsine, & Grady, 1991; McCabe & De Judicibus, 2005). People with disabilities who are unwillingly unemployed are especially prone to exhibit depressive symptoms. Worries about loss of income influence an individual's self-concept as well as his or her place in the world. In addition to dealing with the disability, economic pressures subject people with disabilities to an increased risk of mental suffering. In fact, financial strain has been shown to account for about 30% of the impact of unemployment on depression in people with physical disabilities (Turner & Turner, 2004). Another similar research study corroborated the effects of economic weakness on psychological well-being and quality of life among people with MS (McCabe & De Judicibus). In addition, the hidden bias in the hiring process of people with disabilities makes more entry into the labor market even more challenging, even for the most hopeful job seekers (Loo, 2001).

### **The Demands of illness**

In an effort to understand the multidimensional and often idiosyncratic experience of chronic illness, Haberman, Packard, and Woods (1985) proposed the construct "demands of illness." Specifically, demands are the events or experiences that individuals and families attribute to the illness that may tax the family's personal and social resources and thus the family's well being. Demands are the perceptions of individuals; they may vary during the course of an illness. Initially the demands may reflect the direct effects of disease or therapy, whereas later in the illness the demands may reflect personal disruptions and family adaptation. Moreover, individuals within the family may have shared or divergent views about the nature of the demands (Haberman et al., 1985; Munet de Vim, 1984; Germino, 1984; Gotay, 1984). In summary, the response to chronic illness in a family member may depend on the nature and course of the illness, itself, as well as on the demands perceived by family members. Stetz, Lewis and Primomo (1986) found that families in which the mother had a chronic illness coordinated their own internal efforts to manage more than a third of their problems. Internal household management of problems included provision of concrete aid, affirmation and physical affection among family members, as well as alteration of household roles and routines. The families sought information or services from outside the household for about 20 percent of the problems they faced. These authors suggest that the types of support appropriate for families include information about a problem, an opportunity to discuss concerns with both professionals and nonprofessionals and spiritual support.

### **Objective**

To verify the relationship between adult onset chronic illness or acquired disability and psychosocial adaptation including employment, social relationships, independent living, leisure, functional status, and quality of life 6 months or longer after the injury.

To study the effectiveness of rehabilitation programs on quality of life and psychosocial function in people with chronic illnesses and acquired disability.

### **Review of literature**

In responding to chronic illness, individuals continually test the meanings attached to their distorted situation against the reality of everyday experience. It is a condition of risk because individuals cannot be confident that others will share their own developing perceptions and meaning of the situation. Whether in the familiar setting or in interactions with professional caregivers. Calls for help may turn out to produce unwanted dependence and calls for sympathy run the risk of rejection. Only the passage of time alongside trial and error can provide rule as to the nature of the risks involved in living with a particular condition, though a degree of impulsiveness will always remain. Robinson (1988) for example, shows that patients with multiple sclerosis report being at risk of having their symptoms misunderstood as signs of mental illness, malingering or even being drunk by those not in the know. Even with those in the know, "any claims which allow people social exemptions are likely to be scrutinized by others" (Robinson 1988: 113).

It is comprehensible, from this viewpoint, that studies such as Robinson's should emphasize uncertainty as a key feature of disruptive experience, especially around the appearance and the onset of the condition. Symptoms of chronic illness, in their early stages often overlap with a range of normal behaviors, making the problem of early diagnosis particularly difficult.

Interactions and negotiations with others act the illness will be tentative, with the person being unsure of the reality of the condition and yet being pressed into seeking help by the growing insistence of symptoms, or as a result of, or pressures from, significant others (Bury 1982, 1988). In other situation onset might be more dramatically troublesome, throwing present meanings sharply into relief. As Schnider (1989) shows, in his study of epilepsy symptoms may appear 'out of the blue', causing the individual not only to have to take a changed situation, but also the potentially stigmatizing reactions of others. In other cases, such as renal failure, onset may be either rapid or prolonged (J. Morgan 19K8).

These studies illustrate the range of "biographical disruption" occasioned by the onset and early development of chronic illness. Self and others are not only influenced by the social context in which the person lives, but by the nature of the symptoms, and their perception experiences. Conditions which have stigmatizing consequences (whether these are 'felt' or enacted) such as epilepsy (Scambler 1989) or cancer (Macdonald 1988, Kelly 1986) may create an urgent need to reduce any likely negative impact of the diagnosis. Kelly, for example, calls for the physician to recognize the element of grief involved in cancer diagnosis and curative surgery, and for communication with the patient around such feelings, Bardiey (1988) suggests that doctors should adopt a strategy of working to pass on a sense of strength in cancer patients. In other conditions such as rheumatoid arthritis (Bury 19S2) and multiple sclerosis (Robinson 1988) the early recognition and naming of the condition may albeit temporarily, help to clear the air' and reduce uncertainty. Primary diagnosis may thus both enable and on damage responses, for example, helping some negotiations within the family, hindering others. However, as a situation develops, a new set of issues to do with explanation and legit imation present themselves.

Robinson (1988) reports number of examples, that people may use the diagnosis of multiple sclerosis to overcome the feelings of being regarded as depressive or mentally ill. A diagnosis may stand for an official validation of the condition. Yet, it is also clear that knowledge about the disease does not guarantee success of trying to create legitimate change, and may continue to slash with others' perceptions in everyday stigma. Personal goals also differ significantly from medical ones even in the health care setting, when doctor and patient are ostensibly communicating about the same problem. Sufferers may disagree about the significance of symptoms, for example by being resistant to the permanent use of a wheelchair long after, the appropriate point on the 'medical trajectory' has been reached (Robinson 1990, see also Zola 1982). Here, again, negotiations will be necessary, in order to produce stability.

### **Theoretical background in the concepts of acceptance and denial**

Freud (1961) first used the concept of denial within the language of defense mechanisms in psychoanalytical theory. Defense mechanisms were identified as procedures used by the ego to avoid the anxiety of a threatening situation. Freud described denial as the refusal to acknowledge the existence of an intolerable situation or the feelings associated with it, and saw it as one of the defense mechanisms used to defend the ego from anxiety. All the way through its use, painful or distressing thoughts and emotions were prevented from toward the inside the consciousness, and this provided time for the ego to become strong enough to deal with a changed situation. Freud viewed denial as functional, but only up to a point. If denial was prolonged, it would lead to pathology. Over the years, theorists have further developed understanding of the defense mechanisms and have extended knowledge about the implications of being in denial (Klein 1975, Hamilton 1983, Dorpot 1985, Joseph 1986, Horner 1991). Kubler-Ross (1969), in her research with people who were dying, identified denial as an early response to grief, defending the person from the painful inevitability of death.

On the basis of this work, she developed a model of grief in which people move through five linear stages of emotional adjustment; these are denial, anger, bargaining, depression and the final phase of acceptance (Kubler-Ross 1969). In her stage model of grief, normal adjustment means that denial gradually diminishes and is replaced with acceptance. When working with people who were terminally ill, Kubler-Ross considered acceptance to be a final stage before death. She later applied her theory to people who were living with AIDS, and viewed acceptance as an adaptive state where the person had reached a stage of peace and acceptance to the inevitable (Kubler-Ross 1987). If acceptance was not attained this was considered to be pathological. Like Freud, Kubler-Ross viewed denial as healthy when it served a protective function in the short term. If prolonged, however, it would result in complicated or pathological grief. Other grief theorists have adapted the stage model of grief theory as a framework for adjustment to loss and have reflected these ideas (Glick et al. 1974, Horowitz 1976/86, Bowlby 1980/81).

The stage model in its different forms continues to have a strong presence in today's understandings about the grief process (Rando 1993, Stroebe et al. 1993); however, both psychoanalytic and grief theories have been challenged (Holmes 1972, 1974, 1990, Shuchter & Zisook 1993). The criticism of Kubler-Ross is that healthcare professionals who adopt the popular five-stage model are paying attention on matching behaviours and emotions with stages of the model. Given this, they may be less likely to listen carefully as a dying person attempts to tell their story of their unique experience.

### **Challenges to the consequence of acceptance and denial**

There is a research that aimed to measure the relationship between coping patterns and health outcomes, many of which promotes this view of acceptance as an adaptive, positive outcome in the adjustment process. In this research commonly reports that behaviors consistent with denial lead to poorer illness management, higher levels of sorrow, and in people adjusting to brain injury, depression (Revenson & Felton 1989, Carver et al. 1993, Karlsen & Bru 2002, Bechtold Kortte et al. 2003, Jones 2003). Understandably, healthcare professionals may hold these understandings; however, research by Reed et al. (1994) challenged the association of acceptance with positive health outcomes. They investigated 74 homosexual men suffering from AIDS who were studying at university. These men were found to react to the disease with a example that reflected 'realistic acceptance' of physical deterioration and death, but this response tended to be linked with reduced survival time. Reed et al. (1994) recommended that the reduced survival time could have been related to behaviors associated with smoking and substance abuse use. Similarly, the work of Greer and colleagues (Greer et al. 1979, 1990, Pettingale et al. 1985) supported a association between 'stoic acceptance' and decreased survival time for women with breast cancer, who were followed by a 15-year period. In other study with people living with cancer has been reported similar findings (Antoni & Goodkin 1988, Dean & Surtees 1989, Jensen 1987).

The conclusion that denial leads to poorer health outcomes has also been indirectly challenged. Impractical positive beliefs about the self and the future are often viewed as characteristics of denial (Kingsbury 2000). In their research into positive illusions, Taylor and Brown (1988) accomplished that people typically hold unrealistically positive views of themselves and the future, and that this is harmonious with mental health. Other researchers provided proof of high levels of unrealistic optimism in the general population (Scheier & Carver 1985, Carver et al. 1989, Scheier et al. 1989). They have also referred to research suggesting that positive illusions help out people to cope with stress or threatening situations such as a diagnosis of cancer. Taylor et al. (1992) researched into a group of men who had been tested for HIV and examined the relationship between AIDS-related optimism and dispositional optimism and indicators of psychological adjustment.

They found that unrealistic positive beliefs about the self, one's situation and the future might be more adaptive than a realistic view (often equated with acceptance). Men who had unrealistic positive beliefs about the future were found to have adjusted better without compromising their health with smoking or substance use behaviors. Quite simply, being unrealistically positive may be a coping mechanism that helps people feel better and is associated with positive social relationships and motivation to work. Further, it appears to aid people to recover from particular health-related stressors (Scheier & Carver 1985, Carver et al. 1989, Scheier et al. 1989). Kingsbury (2000) wrote from the dual viewpoint of being an associate professor of clinical psychiatry and a person living with chronic illness. When discussing reactions and adaptations to chronic illness, he challenged the use of the Kubler-Ross model in understanding adjustment to chronic illness.

He emphasized the importance of sympathy, or viewing a situation from the person's viewpoint, and proposed that varied responses to illness be seen in terms of the experience of adjustment rather than being understood as stages. He suggested that 'errors arise when pathologising generalizations are extended to the chronically ill'. Just as Taylor and Brown (1988) contend, Kingsbury (2000, p. 4) also maintains that unrealistic hope or optimism (often interpreted as denial) is 'often a valuable and healthful aspect' of normal human psychology. Kingsbury stressed on the importance of avoiding the labeling of behaviors, and explained that such behaviors are part of the complicated process of adjusting and adapting to chronic illness. In spite of a common reliance on acceptance and denial as accurate descriptors of the reaction to chronic illness, study have shown that there are differing views about the place of these concepts in describing the experience of adjustment. That denial is maladaptive and at least questionable, as is the notion that achievement of acceptance is pleasing. Questions have been raised about the reliability of these concepts from within the medical perspective. The study now considers the impact of imposing such labels on people who are learning to live with chronic illness.

### **Alternative interpretations of illness experience**

It is essential to find the understandings of the way people react to chronic illness that are alternatives to the Kubler- Ross stage model. Paterson (2001) offered a view of the experience of chronic illness that emphasized fluctuations in the person's attention to symptoms all the time. Opposing to the understandings of a predictable illness trajectory of phases, Paterson (2001, p. 4) viewed the experience of chronic illness 'as an ongoing, continually changing process in which people experience a complex dialectic between themselves and their world'. Through this process, people experience-shifting perspectives and can make sense of their experiences. A standpoint is characterized by beliefs, perceptions, expectations, attitudes, needs, and experiences about the meaning of living with chronic illness in a specific framework. No perspective is the right one; rather, it simply informs the response to illness at that time. Within this model, the perspectives of 'illness in the foreground' and 'wellness in the foreground' shift on the base of changes in personal or social context. During the 'illness in the foreground' perspective, the burden of illness can affect extremely on a person's life, and people are inspired with the suffering and loss experienced. The strong spotlight on the illness often means that they cannot effectively attend to other aspects of their lives or they are overwhelmed by the illness. However, this perspective may serve the function of protecting the person from confronting steep realities, of getting an identity as a sick person, or of conserving precious energy at critical times. Having a strong focus on the illness also fosters learning about living with it. Conversely, during the 'wellness in the foreground' perspective, the person views the illness as an occasion for change or growth and the focus is on the self as separate from the body.

There is a sense of control and the body is distanced from the self, and the focus falls on emotional, spiritual and social aspects of life. People have usually learned a great deal about the illness and have developed networks and resources where there is reciprocal support and understanding (Paterson 2001). They move between these views and respond to the experience of chronic illness accordingly. Kralik (2002) formed collaborative, long-term relationships with 81 women who were living with a diverse range of chronic illnesses. Narrative data revealed that the women appeared to move through an extraordinary' phase of turmoil and distress when first faced with chronic illness; however, over the time many were able to make the change towards incorporating the chronic illness into their lives. This phase was conceptualized as an ordinary' phase, as illness became an ordinary part of their lives. A sense of mastery and control pervaded. It was clear that an individual woman's journey along the pathway was unique and not necessarily straightforward. The transition from extraordinariness to ordinariness and back again were found to occur in a non-linear mode, sometimes cyclical, often convoluted and potentially recurring throughout a woman's lifetime as changes brought about new challenges.

People who live with chronic illness do not want to be seen as diminished. If we understand the fluctuating response to long-term illness from the perspective of motivated to fit with social norms and maintaining a sense of power and control, it becomes possible to understand behaviors as a person's attempt to preserve a valued sense of self and identity. The fluctuating illness experience seems as the individual navigating their way through an often unsupportive and sometimes hostile social context. The research challenge that labels of acceptance and denial are not helpful and may block this process. Rather, the willingness to listen and to understand what is happening for the person at the same time, resisting the temptation to categorize, and honoring their account will go a long way in assisting them to feel respected and truly supported. This approach is likely to foster a valued sense of self.

### **Conclusion**

Healthcare specialists and unskilled people commonly refer to the terms acceptance and denial when describing a person's response to chronic illness. For whose people who understanding of the illness experience relies on the acceptance and denial framework may not pay attention when people with chronic illness attempt to tell their own unique story of how they have experienced life with same condition. Instead, their concentration may be focused on right aspects of the experience with stages of adjustment. When others use labels of acceptance and denial, people who are learning to live and adopt themselves with a chronic illness may internalize these labels as reflections of the self. This may be more likely when the person using the label is perceived to have authority, such as a healthcare professional. The internalization of negative information linked with these labels may block the reshaping of self-identity that is fundamental when making a transition to living well with chronic illness. The results of recent studies on chronic illness suggest the need for a multidimensional view of its impact on everyday life.

The research has shown considerable diversity in the ways in which people actively attempt to alleviate biographical disruption and enhance adaptation. In Geertz' terms, the research duty involves taking experience near concepts and placing them in illuminating connection with experience distant concepts (Geertz 1983, 58). The need to consider the wider context is important at a time of rapid change in the health held. For example, changes in the culture surrounding health, may have important implications for our understanding. As Blaxter (1990) has recently pointed out the current emphasis on 'healthy lifestyles' may have a negative effect in chronic illness, where symptoms can limit their adoptions. While such changes in the cultural climate may be attractive to some groups and individuals, they may be new sources of concern for others (Anderson and Bury 1988: 250-252).

## **Methodology**

### **Tools**

SF-12health survey questionnaire, a set of 12 questions selected from the SF-36 that taps eight health domains: Physical Functioning, Role-Physical, Bodily Pain, General Health, validity, social functioning, Role-Emotional, and Mental Health (Ware, Kosinski and Keller, 1998). Like the SF-36, the SF-12 is a generic HRQoL measure that can be used with people with health conditions to compare the relative burden of disease and the effects of interventions. Spiritual Well-Being Scale (SWBS: Paloutzian & Ellison, 1991). The SWBS is a self-report instrument designed to assess the subjective quality of life. It is comprised of two 10-item subscales, the Religious Well-Being (RWB) and the Existential WellBeing (EWB) scales, to gauge the construct of spiritual well-being. Each item uses a 6-point Likert-type scale ranging from 6 = strongly agree to 1 = strongly disagree to indicate the extent of agreement.

Acceptance of Disability Scale-Revised (ADS-R: Groomes & Linkowski, 2007). The ADS-R is a 32-item self-reporting measure of adjustment to disability among people with disabilities. Each statement is rated on a 4-point Likert-type scale ranging from 1 = strongly disagree to 4 = strongly agree. Possible scores on the ADS-R range from 32 to 128. A low score reflects a low level of acceptance of the disability. The ADS-R was adapted and modified from the original 50-item Acceptance of Disability (AD) Scale, constructed by Linkowski (1971). The Cronbach's alpha for the ADS-R in the present study was .

Hope Scale (HS: Snyder et al., 1991). The HS is a 12-item self-referent multidimensional cognitive appraisal designed to reflect the relative level of hope pertaining to goal-related activities.

State-trait anxiety inventory (stai-Y1 and stai-Y2)(Spielberg, 1989)

State-Trait Anger Expression Inventory (STAXI)

STAXI was developed by Spielberger (1983).STAXI is a self-rating scale with 34 items, which measures the experience and expression of anger. The STAXI also contains 4 sub-scales designed to assess 4 different dimensions of the expression of anger: (a) Anger-In (8 items), (b) Anger-Out (8 items), (c) Anger-Control (8 items), and d) State anger (10 items). It is rated on a four-point scale (not at all, a little, sometimes, and always).

### **Sample**

The sample will consist of 30 subjects. Participants will range in disabilities that are at least 18 years of age. All subjects (experimental group) will receive all tests and then they will received rehabilitation programs for 4 months (3days a week) and after that they will receive same tests. NO pharmacological treatments.

- Control group will consist of 30 subjects. They will receive also all tests same with experimental group and after 4 months (without rehabilitation) again will test. NO pharmacological treatments.
- Design of the study is to compare to treatments: a rehabilitation program (experimental treatment), a non-rehabilitation program (control treatment) and to declare the effectiveness of rehabilitation methods.

### **Types of disabilities and chronic illnesses**

Traumatic brain injury (TBI), posttraumatic stress disorder (PTSD), multiple sclerosis (MS), people with amputation.

### **Interventions**

Four months rehabilitation programs encompassing weekly 3-hour group sessions include of music therapy, relaxation, positive thinking .all programs focus on shaping social behavior and remediating social perception and 1-hour individual sessions to address psycho logic issues with mood, self-esteem and quality of life.

## Music Therapy

Music Therapy is a branch of psychology wherein its mental, physical, emotional, social, aesthetic and spiritual, all the aspects are, individually or combined, to address people's needs. The needs of the client or the patient can be addressed either through the direct use of music or through the relationships that develop between the client and the therapist. Music therapy can be used with individuals of all ages, to help the body fight various diseases and conditions. Music therapy can counteract the damaging effects of chronic stress by altering the breathing and heart rate. Music helps keep anxiety and depression at bay by bringing more positive state of mind. Listening to music can enormously increase optimism and control pessimistic aspects, like worry, bias and anger. Patients in the study group, during the procedure will expose to approximately 30 min of music therapy.

## Relaxation

The relaxation audiotape contained information that led the subject through breath focus, body scan, and meditation. Breath focus involves focusing on the rhythm of the breath, body scan means to focus on different body parts as one inhale and to relax that body part as one exhale, and meditation means to focus on a neutral word or phrase in rhythm with one's breath.

## Anger management technique

By training our mind to look at frustrating situations in a more realistic manner, we can free our self from a lot of unnecessary mental suffering. Conveying anger feelings, making sarcastic remarks, slamming doors, arguing with others, striking out when infuriated, saying nasty things, losing their temper, and expressing their feelings if annoyed during the session

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