Applied Psycholinguistics

Positive effects and ethical perspectives

Vol. II

Edited by Giuseppe Mininni and Amelia Manuti

Saggi e studi

PSICOLOGIA

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In memoriam of the ISAPL founder

We have believed and firmly hoped to host Tatiana Slama-Cazacu since the last three days before the opening of the IX Isapl Congress, whose selected proceedings are here published. She nourished such trust in many ways, but she finally explained that her health conditions wouldn't have allowed her to move, despite all the support we surely would have supplied her. Nonetheless, we know that she would have been happy in Bari, as she was the five times she visited Bari during the last quarter of century. During the congress we constantly perceived her presence thanks to her daily phone and email contacts. The Bari scientific committee was very happy to receive her congratulations and compliments for the organization abilities shown.

By dedicating these volumes to Tatiana Slama-Cazacu we all feel touched not only for the suspended joy for the missed rendez-vous with her, but most of all for the acute sorrow which has struck the Isapl friends when receiving the sad news of her death on the 6th of April 2011.

Giuseppe Mininni & Amelia Manuti

Language and Social Context

To be (ill) or to have (a disease)?

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The chronic diseases are increasingly widespread today because of the progressive rise in the average age of the population. The management and treatment of these diseases has become very expensive for all countries and their health institutions; furthermore, the inappropriate management of the disease by the patients very often engenders problems within health care settings (overcrowding of emergencies, endless waiting lists at the specialist practitioners...). Indeed, the early onset of complications and the occurrence of repeated crises, very often due to a lack of "compliance" on the part of chronic patients, frequently lead them to the emergency departments, force their physicians to repeat hospital admissions (admissions for chronic diseases represent more than 75% of all hospital admissions) and create work or school absenteism.

It cannot be denied that the chronic diseases require a complex management, which is highly problematic for physicians, healthcare workers and patients. Furthermore, while in the case of an acute disease, the patient has to let the physician decide for him, in a chronic disease condition the patient shares with the physician the responsabilty for the management of his illness (as the patient decides if he wants to comply or not with the treatment prescribed by the physician). Nowadays, these patients show a lack of compliance (adherence to the medical advice) which arises from several factors. The daily commitment that these diseases require is laborious and often considered "useless" when the disease is "silent". Moreover, the onset of a chronic disease is inserted in the trajectory of life as an element of breakup, it attacks the physical an psychological integrity of the individual and can become an unacceptable event; to accept the illness means, to some extent, to admit ones own limits. In addition, this acceptance results in the need to cope with a new life, to adopt other lifestyles.

The changes in behavior will take time, will be influenced by several psychological factors (the patient's locus of control, his coping, his self-esteem, his self percept of efficacy, his representations of health, of the illness, of the treatment, …) and will follow different stages (according to the Prochaska- Di Clemente model: pre-contemplation, contemplation, preparation, action, maintenance, relapse) until the final acceptance of the disease occurs.

The psychological impact of a chronic disease is certainly reflected in the patient's language which differs, somehow, therefore, from the doctors's language. Here, we hypothesize that the use of the verbs "to have" and "to be" on the part of the patient might be predictive of his acceptance of the disease and, therefore, of his availability to therapeutic patient education. Accordino to WHO Therapeutic Patient Education is considered, indeed, as «a strategy for developing the patients' empowerment, enhancing his compliance and making him become autonomous in managing his disease».

To be ill or to have a disease? Anthropologists of medicine distinguish the biological alterations (disease), the subjective experience of the ill person (illness) and the social experience of the pathological condition (sickness) (Kleiman, 1988). We are not interested here in discussing this issue, rather in underlying the different use of the verbs "to have" and "to be" on the part of the patient and of the physician and the positive effects of such an analysis.The question still seems to be very actual and to represent the subject of an interesting discussion in the context of medical practice.

This distinction already existed at the time of ancient Greece: for Ippocrate the person "was" ill, for Galeno she "had" a disease. For the first, medicine is asked to consider the person as a unit, to take into account the physical and psychological aspects of the individual; its end is to take care of the body as a whole in order to reconstitute balance. For Galeno and his School, the organism is a "whole" made up of parts and the illness didn't create unbalance, it rather strikes a part of the body that must be treated. Still today the medical thought oscillates among these two positions (the person, the disease) and issues to the physician the challenge to succeed in conjugating them.

If, on one side, the use of these verbs, "to be" and "to have" reflects a different conception of medicine (olistic or riductionist), on the other one it translates a different way of considering the patient and the disease. We observe, indeed, that a person might "have" a lot of acute diseases/conditions:

- an abscess, un abcès, un ascesso;
- an aneurysm, une rupture d'anéurysme, un aneurisma;
- a myocardial infarction, un infarctus du myocarde, un infarto del miocardio;
- a pain (acute or chronic), une douleur, un dolore;
- a nephretic colitis, une colique néphrétique, una colica renale;
- a stroke, un accident vasculaire cérébral, un incidente cerebrale vascolare;
- a peritonitis, une péritonite, una peritonite;
- a cystitis, une cystite, una cistite;
- a glaucoma, un glaucome aigu, un glaucoma;
- a pneumonitis, une pneumonie, una polmonite;

and might also "have" some chronic diseases:

- a dermatitis, une dermatite, una dermatite;
- the Crohn's disease, la maladie de Crohn, il morbo di Crohn the Gilbert's disease, la maladie de Gilbert, la malattia di Gilbert, a leucemia, une leucémie, la leucemia celiachia, la maladie coeliaque, la celiachia;
- an epatitis, une hépatite, l'epatite, a lupus, un lupus, il lupus, an Alzheimer, la

maladie d'Alzheimer, l'Alzheimer, an Arthrosis, une arthrose, l'artrosi a spastic colon, une colopathie fonctionnelle, il colon spastico an adenoma, un adénome, un adenoma;

or a chronic health problem:

- a gout, une gotte, la gotta an ulcer, un ulcère, un'ulcera.

If it's true that one can "have" chronic o acute diseases, it is also true that some pathologies – mostly chronic ones- are accompained just by the verb "to be" (we say, for example,

- "to be obese" and not "to have obesity" – "être obèse et non avoir une obésité" – "essere obeso" e non "avere una obesità";
- "to be anorexic/bulimic" – not "to have l'anorexia/bulimia" – "être anorexique/boulimique et non pas avoir une anorexie /boulimie", "essere anoressico/bulumico" – non "avere l'anoressia/bulimia" but
- "to suffer from anorexia/bulimia" – "souffrir d'une anorexie/boulimie" – "soffrire di anoressia/bulimia").

Other diseases-and fall into this group most chronic diseases-are preceded by the verb "to be" or "to have" without distinction (i.e.: to have a heart disease, to be cardiopatic – avoir une maladie de coeur/être cardiaque – avere una malattia cardiaca, essere cardiopatico; to have haemophilia, to be haemophiliac – to be haemophiliac, etre hémophile – avere l'emofilia, essere emofilico).

The verb "to be" expresses a state, a condition and involves the risk of bearing a stigma, being the disease not only an experienced but also a social construction.

The verb "to have" enacts a distance between the sick person and the disease and let us assume that one "has" a disease which he wan't "have" anymore tomorrow; however, even if the disease we "have" is our, we do not identify ourselves with it.

Perhaps this is the reason why the verb "to be" is more rarely used in the case of an acute disease.

This debate affects primarily the field of chronicity and the way patients and physicians express themselves. It results from our preliminary investigations that general practicionners who want to reassure their patients have a greater tendency to use the verb "to have" (frequently associated to "some"):

- to have (some) bronchitis, (some) hypertension, (some) diabetes, (some) cholesterol;
- avoir un peu de bronchite, un peu d'hypertension, un peu de diabète, un peu de cholesterol (et non être bronchitique, hypertendu, diabétique cholesterolémique). Par contre le patient dit: j'ai du diabète et quand il veut faire valoir un droit: je suis diabétique…;
- avere "un po'" di bronchite, "un po'" di ipertensione, "un po'" di diabete, il colesterolo "un po'" elevato.

On the opposite, the specialist might be more direct making the patient feel that he belongs to a defined category, e.g.:

- the diabetic, le diabétique, il diabetico;
- the asthmatic, l'asthmatique, l'asmatico;
- the bronchitic, le bronchitique, il bronchitico;

- the obese, l'obèse, l'obeso;
- the hypertensive, l'hypertendu, l'iperteso;
- the epileptic, l'épileptique, l'epilettico;
- the schizophrenic, le schizophrène, lo schizofrenico;
- the depressed, le déprimé, il depresso;
- the hysteric, l'hystérique, l'isterica;

and to use the verb "to be".

He also easily uses expressions such as "oncologic patient", "allergic patient", "patient cancéreux", "patient allergique", "paziente oncologico", "paziente allergico", especially when talking with colleagues, and often addresses to the patient telling him "you are obese, asthmatic", "vous êtes asthmatique, obèse", "lei è obeso, asmatico", making him feel immediately "definitely sick" and letting him understand that he falls into a certain "category" to which he would not like to belong. Many patient's reactions (for example, revolt; poor compliance) and several subsequent disturbances in the doctor-patient relationship might derive.

The patient says, instead: " have hemophilia", "I have an allergy"; "j'ai l'hémophilie, j'ai une allergie", "ho l'emofilia, ho una allergia" in the first case to move away from a disease that scares him (often because someone in his family allready suffered from it with serious consequences), in the second case because he doesn't consider allergy a real disease-he can also say, however, "I am allergic"-"je suis allergique"-"sono allergico".

Moreover, always to divert from the stigma of the disease, he will say:

- "I have incontinence" rather than "I am incontinent"; "j'ai une incontinence" plutôt que: "je suis incontinent" "ho una incontinenza" piuttosto che "sono incontinente";
- "I have a colostomy" rather than "I am colostomized", "j'ai une colostomie" plutôt que "je suis colostomisé", "ho una colostomia" piuttosto che "sono colestimizzato".

And again, he will tell about himself in relation to a pathological condition, saying:

- "I'm overweight" (rather than "I am obese"), "je suis en surpoids" (plutôt que: "je suis obèse"), "sono in soprappeso (piuttosto che "sono obeso");
- "I have a Parkinson" (instead of "I am parkinsonian") "j'ai un Parkinson" (au lieu de: "je suis parkinsonien"), "ho un Parkinson" (invece di "sono parkinsoniano").

He will mostly not say:

- "I am diabetic", "Je suis diabétique" "sono diabetico" or "I am hypertensive", "je suis hypertendu", "sono iperteso" but "I have diabetes, I have high blood sugar level, I have high blood pressure", "j'ai un diabète, j'ai trop de sucre dans le sang, j'ai une tension artérielle élevée", "ho il diabete, ho un livello elevato di zucchero nel sangue, ho la pressone alta";
- "I have a cancer" – "j'ai un cancer, plutôt que: je suis cancéreux", "ho un cancro".

However, he might say "I have a depression" or "I am depressed", "Je fais une dépression," o "Je suis déprimé", "ho una depressione" o "sono depresso".

The theme of “to be” or “to have” has interested, in recent years, the American Diabetes Association, who considered important to suggest the clinicians to adopt the expression “person living with diabetes” or “people with diabetes” to emphasise that the expression “be diabetic” scares the patient and makes him take distance.

The expression “person with…(asthma, HIV,…)”, “personne vivant avec un asthme,…”, “persona con…” is nowadays adopted even for other pathologies. The argument that the patient feels the weight of the stigma represented by his disease when using the verb “to be” is often contested by those who mantain that the use of the verb “to have” has led to a delay of several years in the assumption of drugs on the part of diabetics and hypertensives. If we analyse the expressions used by diabetic adolescents, it seems clear that in many cases they refuse the condition of being sick and do not use the verb “to be” referring to their pathology. As we know, adolescence is a period of revolt, of challenge. After having accepted their chronic disease, adolescents seek to dominate it in some ways (for example, climbing mountains: Maldonato, 2009).

As far as HIV is concerned we notice a tendency on the part of the patients to call themselves “HIV positive” (“sero-po” en français; “sieropositivo” in italiano) in order to express the sense of belonging to a category which is recently increasing his “empowerment” in contrast with the physicians’ “power”; many other patients hide the fact that they “are seropositive” to avoid the stigma of the disease. We also observe that neither physicians nor patients use the expression “to have a reaction of sieropositivity”, unlike all other reactions.

The observations here expressed concern, in particular the health care personnel dealing with therapeutic patient education, «a process aiming to let people suffering from a chronic disease acquire the skills required to manage their disease as autonomously as possibile and maintain or improve their quality of life» (OMS, 1998). Educational programmes for patients of all ages are nowadays carried out (in all the specialistic areas of medicine) for people suffering from the following diseases or conditions:

- ALLERGOLOGY: asthma,food allergies;
- CARDIOLOGY: HTA, myocardial infarction, heart failure;
- DERMATOLOGY: atopic eczema;
- ENDOCRINOLOGY: diabetes type I and II, obesity;
- HEMATOLOGY: haemophilia, therapy with anticoagulants;
- IMMUNOLOGY: LEDs, HIV;
- NEPHROLOGY: renal failure, self dyalisis;
- NEUROLOGY: epilepsy, parkinson disease, chronic pain management;
- OBSTETRICS: preparation for birth, postpartum self care;
- ONCOLOGY: colostomy, pain management;
- OTORHINOLARYNGOLOGY: laryngectomy, Menières disease;
- PNEUMOLOGY: asthma, BPCO, chronic respiratory failure, cystic fibrosis;
- PSYCHIATRY: schizophrenia;
- RHEUMATOLOGY: arthritis;
- SURGERY: transplants surgery, bariatic surgery.

Therapeutic patient education aims to make the patient responsible for the management of his pathology, no longer dependent on the constant advice of a doctor, but able to apply his competences of self-care and of adaptation to the disease. The person that declares "to be" sick is supposed to consider herself responsible of the course of her illness and will make efforts to delay complications and to prevent the crises, acquiring knowledge and abilities.

The use of the verb "to be" or "to have" on the part of the patient might reveal his disposition towards education. It is evident that when a person declares to be "asthmatic, hypertensive, diabetic,…" somehow she identifies herself with her illness, she shortens the distance between herself and the disease. When, instead, she says "to have some asthma, some diabetes" she implicitly declares not to have overcome one of the steps that bring to the illness acceptance and to be, for instance, in the phase of "revolt" or "denial". We know that a patient finds difficulties in learning, in acquiring new knowledge or abilities when he is in one of these stages and that, therefore, he is not ready to be introduced into an educational program. In other words it is assumed that the person who claims to "be" ill is more receptive to therapeutic patient education than the one who claims to "have" a disease. We are actually engaged in an international research protocol to test the validity of this hypothesis. In conclusion, some positive effects of this reflection on the use of these two verbs in the healthcare setting could be stressed:

- it encourages health professionals to try to identify, among the terms used by the patient, some tracks highlighting his relationship with the disease and, as it has been said, it helps to understand whether he may benefit or not from an educational program, if he is able to assume the responsibility of daily managing his disease;
- it encourages the medical staff to listen to the patient; recognizing that the disease may have an impact on the emotional life brings the practitioner to look at the "interiorità" (inside) of sick people; listening, through which the identification of the expressions revealing the experiences of the sick person takes place, is a key component of the doctor-patient relationship and an important requirement to achieve compliance;
- it stimulates the health care professionals to use words, expressions, attitudes appropriate to the present state of the patient and of his degree of acceptance of the disease.

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Motivation for change in psychotherapy

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1. Introduction

Various motivational approaches in literature have been developed in an attempt to prevent patients from dropping out of treatment, to increase their active engagement end, hence, to improve the short-term and long-term outcome of therapy. In most cases motivation is intended as a cognitive quality and lack or falls in motivation (relapses) are usually seen as weakness of the will (Romaioli *et al.*, 2008).

On the contrary, in the transition from modern to post-modern psychology, the very concept of motivation does not issue from a well-formed and orderly cognition at the centre of our being, but originates in a person's vague, diffuse and unordered feelings — their sense of how they are 'positioned' in relation to the others around them (Leiman, 2002). Offering a critical review of the literature on this theme (Baktin, 1981,1984; Vygotsky, 1962; Shotter, 1993a, 1993b; Cheyne & Tarulli, 1999; Volosinov, 1986) we intend to discuss some suggestions about how to analyse positions using discourse analysis.

2. What is change? In which way do people change?

In everyday speech "change" is represented in contrast to permanence, and they are viewed as being complementary. "Change" and "non-change" narratives are strictly linked to motivational rhetoric in the sense of *will* and *determination*: "he/she is not ready for change" "he/she hasn't decided to change yet", "unless he/she decides to change, no one can help him/her".

Many theoretical models have been pointed out in order to explore the theme of change, i.e. the motivational interview (Miller and Rollnick, 1991), the Socratic method (Vitousek *et al.*, 1998), the trans-theoretical model of change (DiClemente, 1999; Prochaska & DiClemente, 1982) and the Self-Determination Theory (Deci and Ryan, 1985). These models, despite representing different approaches, share two fundamental presuppositions (Romaioli, 2009): the first one is that motivation