Psihološka dimenzija tjelesnog invaliditeta

Psychological dimension of physical disability

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Sažetak

Pojava tjelesnog invaliditeta kod osobe uzrokuje snažan emocionalni odgovor. Taj složeni obrazac individualnih reakcija determiniran je različitim čimbenicima i emocionalnim potrebama. Promjene u psihičkom i emocionalnom životu osobe, percepcija o vlastitom invaliditetu, ograničenja koja proizlaze iz tjelesnog invaliditeta i negativni stavovi okoline samo su neki od čimbenika psihološke dimenzije invaliditeta. U suočavanju s novonastalim tjelesnim invaliditetom osoba se koristi strategijama suočavanja u cilju ponovnog uspostavljanja narušene ravnoteže. Ukoliko izostane podrška okoline, utoliko će proces suočavanja i/ili prilagodbe biti otežan ili onemogućen. Strategija suočavanja s novonastalim tjelesnim invaliditetom neće se adekvatno odvijati i razviti, što se može negativno odraziti na fizičko, psihičko, socijalno i duhovno funkcioniranje osobe. Psihološka dimenzija tjelesnog invaliditeta može biti presudna u procesu suočavanja s nastalim tjelesnim invaliditetom, postizanju samostalnosti, razvijanju otpornosti prema vanjskim pritiscima i samoostvarenju osobe. Medicinske sestre aktivno sudjeluju u procesu suočavanja i prilagođavanja osobe s tjelesnim invaliditetom na novonastalo stanje.

Ključne riječi: osobe s tjelesnim invaliditetom, tjelesni invaliditet, emocije, suočavanje, stres, medicinska sestra

Kratak naslov: Psihološka dimenzija invaliditeta

Abstract

The appearance of a physical disability in a person causes a strong emotional response. This complex pattern of individual reactions is determined by various factors and emotional needs. Changes in one's psychological and emotional life, perception of one's disability, limitations resulting from physical disability, and negative environmental attitudes are just some of the factors of the psychological dimension of disability. A person facing a physical disability uses coping strategies to restore the disturbed equilibrium. If support from the environment is absent, the process of coping and/or adaptation will be very difficult or impossible. The coping strategy for facing new physical disabilities will be unsatisfactory, which can have a negative impact on physical, psychological, social, and spiritual functioning. The psychological dimension of physical disability can be crucial in the process of facing the resulting physical disability, achieving independence, developing resistance to external pressures, and personal self-actualization. Nurses participate actively in the process of coping strategies and adopting a person with a physical disability to a new condition.

Keywords: people with physical disability, physical disability, emotions, coping, stress, nurse

Running head: Psychological dimension of disability

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Uvod

Suvremena svakodnevnica prepuna je nepredvidivih stresnih podražaja uzrokujući vrlo dinamičan životni ritam. Kad uz navedene svakodnevne stresne izazove dođe do oštećenja zdravlja i posljedičnog invaliditeta, osoba i članovi obitelji mogu se naći u teškoj i vrlo izazovnoj životnoj situaciji. Pojavnost trajnog tjelesnog invaliditeta snažan je izvor stresa koji zahtijeva prilagodbu i može se negativno odraziti na fizičko, psihičko, socijalno i duhovno funkcioniranje osobe [1 – 4].

Tjelesni invaliditet predstavlja trajno ispodprosječno tjelesno funkcioniranje različitog uzroka i pojavnosti [1, 5]. Različit stupanj onesposobljenosti koji je nastao uslijed tjelesnog oštećenja organa i organskog sustava može rezultirati smanjenim, ali i potpuno onemogućenim tjelesnim funkcioniranjem s posljedičnim većim ili manjim gubitkom samostalnosti u izvršavanju i zadovoljavanju osnovnih ljudskih potreba [1, 6]. U usporedbi s uobičajenim načinom i

Introduction

Modern everyday life is full of unpredictable, stressful stimuli, causing a very dynamic rhythm of life. When, in addition to daily stressful challenges, there is damage to health and consequent disability, a person and family members can find themselves in very challenging life situation. The occurrence of permanent physical disability is a strong source of stress that requires adaptation and can have a negative impact on the way a person functions physically, psychologically, socially, and spiritually [1–4].

Physical disability represents permanent below-average physical functioning of different patterns and occurrences [1, 5]. Different degrees of disability caused by physical damage to organs and organ systems can result in reduced, but also completely disabled, physical functioning with a consequent greater or lesser loss of independence in fulfilling and satisfying basic human needs [1, 6]. Compared to the usual way and circumference of functioning in terms of activities and opsegom funkcioniranja u okviru aktivnosti i ponašanja, ove osobe nerijetko nisu u mogućnosti ispuniti zahtjeve svakodnevnog života [1, 7]. Unatoč navedenom, psihološka dimenzija tjelesnog invaliditeta jednako je važna jer može biti presudna u postizanju samostalnosti, otpornosti prema vanjskim pritiscima i samoostvarenju osobe [2, 8].

Iskustvo tjelesnog invaliditeta nije isto kod svih osoba s tjelesnim invaliditetom jer njegovi učinci ovise o brojnim čimbenicima kao što su spol, dob, okolina u kojoj osoba živi i drugi čimbenici [8]. Okolina je jedan od ključnih čimbenika jer svojim prihvaćanjem ili neprihvaćanjem različitosti značajno utječe na pojavnost emocija, proces suočavanja, prilagodbu i konačno prihvaćanje nastalog tjelesnog invaliditeta. Navedeno se odražava na osobnost osobe i može imati dalekosežne posljedice na sve aspekte života osobe [1]. Ovisnost o pomoći drugih može kod osobe izazvati snažan osjećaj gubitka popraćen razočaranjem u sustav vrijednosti, emocionalnom boli i patnjom, osjećajem krivnje, strahom, osjećajem neugode, srama i izigranosti, kao i drugim različitim negativnim emocijama. Međutim, suočavanje s vlastitim invaliditetom i novim izazovima života može se, ali i ne mora, manifestirati u negativnom kontekstu. Nerijetko osobe suočene s invaliditetom ostvare novu dimenziju vlastita života, u čemu važnu ulogu mogu imati ne samo unutarnji motivacijski čimbenici nego i podrška okoline [1].

Razmatrajući tjelesni invaliditet kao stresni podražaj, emocionalne potrebe i proces suočavanja s pojavnošću tjelesnog invaliditeta, ovaj rad pojašnjava značaj psihološke dimenzije u procesu prilagodbe i razvijanja strategije suočavanja. Cilj je ovog rada opisati psihološku dimenziju tjelesnog invaliditeta da bi se prikazao njezin doprinos u kontekstu samoostvarenja osobe i inkluzije u društvenu zajednicu.

Aspekti tjelesnog invaliditeta

U neraskidivoj interakciji s okolinom mogući su različiti segmenti oštećenja čovjekova zdravlja. Pri tome, zdravlje i njegovo oštećenje razmatraju se kao uzajamna interakcija bioloških (genetska predispozicija, ozljede, bakterije, virusi, patološke promjene i dr.), psiholoških (stres i suočavanje, ponašanje, sustav vrijednosti, stavovi,) i socijalnih čimbenika (obrazovanje, zaposlenje, socijalni status, vjerska i etnička pripadnost) [9, 10].

Tjelesni invaliditet trajno je prisutan poremećaj koji se manifestira u obliku narušenog oslabljenog ili potpuno onemogućenog tjelesnog funkcioniranja osobe. U poimanju uzročnosti tjelesnog invaliditeta razlikuju se dvije ključne podjele tjelesnog invaliditeta: invaliditet koji je nastao uslijed deformacija i tjelesnih nedostataka (nedostatak pojedinih udova, deformacija kostura, oštećenje organskih sustava) te invaliditet uslijed poremećaja u živčanom i mišićnom sustavu (oslabljena motorička snaga mišića, smetnje u koordinaciji pokreta i pojavnost patoloških kretnji, poremećaji pokretljivosti uslijed oštećenja mozga i/ili leđne moždine) [1].

Aspekti tjelesnog invaliditeta razmatraju se kroz medicinsku, socijalnu i psihološku dimenziju. Medicinska dimenzija tjelesnog invaliditeta odnosi se na zdravstveno oštećenje koje je uzrokovalo tjelesnu onesposobljenost osobe. To

behavior, people with physical disabilities are often unable to fulfill daily activities [1, 7]. Despite that, the psychological dimension of a physical disability is equally important since it can be crucial in achieving independence, resistance to external pressures, and personal self-actualization [2, 8].

The experience of physical disability is not identical in all people with physical disabilities because the effects of disability depend on numerous factors such as gender, age, the environment in which the person lives, and others [8]. The environment is one of the crucial factors because the acceptance or non-acceptance of diversity significantly affects the appearance of emotions, the process of coping, adaptation, and the final acceptance of the resulting physical disability. That reflects on the person's personality and can have far-reaching consequences on all aspects of their life [1]. Dependence on the help of others can cause in people a strong sense of loss, accompanied by disappointment in the value system, emotional pain and suffering, guilt, fear, embarrassment, shame and betrayal, as well as various other negative emotions. However, facing one's own disability and new life challenges may or may not manifest in a negative context. Often, people who face disabilities achieve a new dimension in their own lives, in which not only internal motivational factors but also environmental support can play an important role [1].

Considering physical disability as a stressful stimulus, emotional needs, and the process of coping with the occurrence of physical disability, this article clarifies the importance of the psychological dimension in the process of adaptation and developing a coping strategy for people with disability. The aim of this article is to describe the psychological dimension of physical disability in order to illustrate its contribution in the context of a person's self-actualization and inclusion in the social community.

Aspects of physical disability

In the inextricable interaction with the environment, different types of damage to human health are possible. Therefore, health and its impairment are considered a mutual interaction of biological (genetic predisposition, injuries, bacteria, viruses, pathological changes, etc.), psychological (stress and coping, behavior, value system, attitudes) and social factors (education, employment, social status, religious and ethnic affiliation) [9, 10].

Physical disability is a permanently present disorder manifested in the form of impaired, weakened, or completely disabled physical functioning of a person. In the understanding of the causation of physical disability, two crucial divisions of physical disability are distinguished: a disability that arose due to deformations and physical defects (lack of certain limbs, skeletal deformation, damage to organic systems) and a disability due to disorders in the nervous and muscular system (weakened muscle motor power, disturbances in movement coordination and the occurrence of pathological movements, mobility disorders due to damage to the brain and/or spinal cord) [1].

Aspects of physical disability are considered through medical, social, and psychological dimensions. The medical dimension of physical disability refers to a health impairment that has resulted in a person's physical disability. That se, primjerice, odnosi na oštećenja lokomotornog sustava, središnjeg živčanog sustava, perifernog živčanog sustava i motoričke jedinice, drugih organskih sustava, kao i oštećenja koja su nastala uslijed ozljeda i/ili trauma [1]. U svojoj iznenadnoj pojavnosti ili progresiji već prisutne bolesti, posljedica je ovih oštećenja onesposobljenost osobe da se kreće i/ili da izvršava druge fizičke aktivnosti, što rezultira smanjenom pokretnošću ili nepokretnošću. Socijalna dimenzija tjelesnog invaliditeta odnosi se na neposredno, ali i šire okruženje osobe s tjelesnim invaliditetom. U ovoj dimenziji ističu se svi oni segmenti koji onemogućuju uključivanje osobe u radnu i društvenu sredinu [5]. Pri tome percepcija okoline može utjecati na navedeno u smislu pozitivnog (inkluzije i integracije) ili negativnog (stigmatizacije i diskriminacije) odnosa prema osobama s tjelesnim invaliditetom. Pedagoška dimenzija tjelesnog invaliditeta može se smatrati pridruženim segmentom socijalne dimenzije, ali se zbog značenja koji edukacija ima u životu ovih osoba razmatra kao zaseban fenomen. Podrazumijeva pojavnost onih otežavajućih okolnosti koje onemogućuju primjereno obrazovanje djece s teškoćama u razvoju, ali i cjeloživotno obrazovanje odraslih osoba s tjelesnim invaliditetom [5]. Psihološka dimenzija tjelesnog invaliditeta odnosi se na samopoimanje osobe, promjene u psihičkom i emocionalnom životu osobe, percepciju o vlastitom invaliditetu, ograničenja koja proizlaze iz invaliditeta te percepciju i negativne stavove okoline. Svi ti segmenti u snažnom su međuodnosu invaliditeta, identiteta osobe i okoline. Svojom isprepletenošću mogu imati snažan učinak na emocionalno blagostanje osobe djelujući time i na ostale dimenzije kvalitete života poput fizičkog i mentalnog zdravlja, obiteljskog i radnog okruženja te socijalnih interakcija [5, 8]. Pritom pozitivno promišljanje, nadanje, samopoštovanje, samoefikasnost, otpornost na stresne podražaje, socijalna osjetljivost i podrška mogu imati dodatne učinke [11, 12].

Sve dimenzije tjelesnog invaliditeta ističu značaj primjerenog pristupa osobama s tjelesnim invaliditetom. Posebno značenje ima holistički pristup u zadovoljavanju osnovnih ljudskih potreba osoba s tjelesnim invaliditetom uzimajući u obzir sve razine Maslowljeve hijerarhije motiva, uvijek ističući pozitivne mogućnosti osobe. Povezanost s članovima obitelji i drugim osobama u neposrednoj okolini doprinosi osjećaju zajedništva i jačanju samopouzdanja. Okolina u kojoj je moguće razvijati pozitivan odnos temeljen na ravnopravnoj osnovi s drugima ima neprocjenjivo važnu ulogu u ostvarenju punih potencijala ovih osoba [1]. Također, napredak tehnologije i razvoja znanosti ističe važnost biopsihosocijalnog pristupa u poimanju međuodnosa osobe, njezina invaliditeta i okoline [9]. Taj se pristup usmjerava na isprepletenost tjelesnog oštećenja (*biološki*), misli, emocija, ponašanja, psihološkog stresa, uvjerenja o strahu/izbjegavanju, trenutnih načina suočavanja (*psihološki*) te društvenih, socioekonomskih, radnih i kulturnih čimbenika (*socijalni*) [13]. Budući da je čovjek u stalnoj interakciji sa svojom okolinom, jednako se ističu sva tri čimbenika [9].

Povezanost holističkog i biopsihosocijalnog pristupa omogućuje da djelovanje svih profesionalaca u skrbi za osobe s tjelesnim invaliditetom bude usmjereno na sve dimenzije čovjekova funkcioniranja. Ovakvim pristupima u pružanju sestrinske skrbi ostvaruje se snažna usmjerenost na osobu

applies, for example, to damage to the locomotor system, central nervous system, peripheral nervous system and motor unit, and other organ systems, as well as damage caused by injuries and/or trauma [1]. In their sudden onset or progression of an already existing disease, these impairments result in the disability of a person to move and/or perform other physical activities, resulting in reduced mobility or immobility. The social dimension of physical disability refers to the immediate and wider environment of a person with a physical disability. In this dimension, all those segments that prevent the inclusion of a person in the work and social environment are emphasized [5]. At the same time, the perception of the environment can influence the positive (inclusion and integration) or negative (stigmatization and discrimination) attitude toward people with physical disabilities. The pedagogical dimension of physical disability can be considered an associated segment of the social dimension, but due to the significance that education has in the lives of these people, it is considered a separate phenomenon. It implies the appearance of those aggravating circumstances that prevent the appropriate education of children with developmental disabilities, as well as the lifelong education of adults with physical disabilities [5]. The psychological dimension of physical disability refers to a person's self-concept, changes in a person's psychological and emotional life, perception of their disability, limitations resulting from disability, and perception and negative attitudes toward the environment. All these segments are strongly interrelated with a disability, the identity of the person, and the environment. With their intertwining, they strongly affect a person's emotional well-being, thereby affecting other dimensions of quality of life, such as physical and mental health, family and work environment, and social interactions [5, 8]. At the same time, positive reflection, hope, self-esteem, self-efficacy, resistance to stressful stimuli, social sensitivity, and support can have additional effects [11, 12]a scale to measure the coping strategies used by people with disabilities to face the disability-related difficulties (caused by both disability itself and by stigma.

All dimensions of physical disability emphasize the importance of appropriate access for people with physical disabilities. Furthermore, a holistic approach to meeting the basic human needs of people with physical disabilities is of particular importance, taking into account all levels of Maslow's hierarchy, always emphasizing the positive possibilities of the person. Connecting with family members and other people in the immediate environment contributes to a sense of community and strengthens self-confidence. An environment in which it is possible to develop a positive relationship based on an equal basis with others has an invaluable role in realizing the full potential of these people [1]. Also, the progress of technology and the development of science emphasizes the importance of the biopsychosocial approach in understanding the interrelationship between a person, his disability, and the environment [9]. This approach emphasizes the intertwining of physical damage (biological), thoughts, emotions, behavior, psychological stress, beliefs about fear/avoidance, current ways of coping (psychological), and social, socioeconomic, work, and cultural factors (social) [13]. Since humans are in constant interaction with their environment, all three factors are equally emphasized [9].

s tjelesnim invaliditetom ističući sve njezine preostale sposobnosti. Osoba se ne promatra kroz njezino kliničko stanje i invaliditet, nego se pružanjem emocionalne i druge podrške jačaju sve sposobnosti koje osoba ima. Obuhvaćaju se svi segmenti koji izravno ili neizravno utječu na postizanje samostalnosti i samopouzdanja što joj omogućuje ostvariti puni potencijal osobe unatoč invaliditetu [1]. U suočavanju i nošenju sa stresnim okolnostima medicinske sestre ključne su osobe u pružanju svih oblika podrške, snažno djelujući na uključenju osoba s tjelesnim invaliditetom u društvenu zajednicu.

Tjelesni invaliditet kao stresni podražaj

Životni izazovi i stresne situacije potiču kognitivnu interpretaciju, aktiviraju stresne mehanizme te potiču proces suočavanja i emocionalnog reagiranja. Pojedini stresni podražaji dio su svakodnevnog života i s njima se čovjek samostalno i s lakoćom suočava. Trenuci poput pojave tjelesnog invaliditeta veliki su stresni podražaji koji mogu narušiti funkcioniranje osobe, a nerijetko i cijele obitelji. U suočavanje s takvim podražajima osoba s tjelesnim invaliditetom ulaže sve svoje napore da bi prevladala ili umanjila njihove posljedice [9]. Tjelesni invaliditet razmatra se kao svjesno emocionalno iskustvo koje uključuje fiziološko uzbuđenje i posredujuću interpretaciju.

Emocionalno iskustvo tjelesnog invaliditeta ima tri komponente: subjektivnu percepciju, fiziološki odgovor i bihevioralni odgovor, odnosno ekspresiju ponašanja [14]. Subjektivna percepcija odnosi se na proces kojim se stresni podražaji analiziraju, povezuju i interpretiraju [15]. Na temelju interpretacije, osoba tomu pridaje određeno značenje, stvara sliku o događaju, sebi, okolnostima i okruženju [15]. Percepcija je vrlo individualna jer svaka osoba na jedinstven način interpretira stresni podražaj. Subjektivno iskustvo na temelju toga može biti različito u rasponu od onih svakodnevnih i jednostavnih, pa sve do onih teških iskustava kao što je pojavnost trajnog invaliditeta [14]. Fiziološki odgovor nastaje uslijed aktivacije autonomnog živčanog sustava i hormonalnog sustava koji su odgovorni za kontrolu i pobuđivanje reakcija. Kateholamini, kortizol i drugi produkti nastali tijekom aktivacije dvaju odvojenih sustava preplavljuju organizam [16]. Javlja se cijeli niz simptoma pobuđenosti organizma: ubrzan rad srca, ubrzano disanje, drhtanje i znojenje dlanova, crvenilo lica. Bihevioralni odgovor podrazumijeva ekspresiju emocija. Može uključivati plakanje, vikanje, uzdisanje, smijanje, grimase i gestikulaciju, ali i mnoge druge reakcije ovisno o osobnosti osobe i društvenim normama [14]. Bihevioralni odgovori omogućuju ekspresiju vlastitih emocija i obznanjivanje istih drugima. Suprimiranje bihevioralnog odgovora i emocija može potaknuti ozbiljne teškoće u fizičkom i psihičkom zdravlju i funkcioniranju osobe. Stoga je verbalizacija osjećaja ključna u procesu prilagodbe, prihvaćanja invaliditeta i za emocionalni život osobe općenito. Također, regulacija emocija kao pokušaj pojedinca da utječe na vlastite emocije i emocije drugih predstavlja još jedan segment koji doprinosi stabilnosti osobe i definiranju emocionalnih potreba [17].

Promjena slike o sebi, identiteta, uloga i odnosa, životnog okruženja i percepcije budućeg života dodatno pojačava

The association between holistic and biopsychosocial approaches enables the actions of all professionals in the care of people with physical disabilities to be focused on all the dimensions of the way humans function. With such approaches in the provision of nursing care, a strong focus on the person with a physical disability is realized, emphasizing all his remaining abilities. A person is not viewed through his clinical condition and disability, but by providing emotional and other support, all his abilities have been strengthened. It includes all the important segments for a person that directly or indirectly affect the achievement of independence and self-confidence, which enables the person to realize his or her full potential despite the disability [1]. In facing and coping with stressful circumstances, nurses are important in providing all forms of support, strongly influencing the inclusion of people with physical disabilities in the social community.

Physical disability as a stressful stimulus

Life challenges and stressful situations stimulate cognitive interpretation, activate stress mechanisms, and stimulate the coping process and emotional response. Some stressful stimuli are usually part of daily life and a person can cope with them independently and easily. However, a moment such as the appearance of a physical disability is a strong stressful stimulus that can impair the way a person functions, and often the entire family. In coping with these stimuli, a person with a physical disability invests all his abilities to overcome or reduce the consequences of disability [9]. Physical disability is considered a conscious emotional experience involving physiological arousal and mediating interpretation.

The emotional experience of physical disability has three components: subjective perception, a physiological response, and behavioral response, i. e. behavioral expression [14]. Subjective perception refers to the process by which stressful stimuli are analyzed, connected, and interpreted [15]. According to one's interpretation, a person attaches a certain meaning to it, and creates an image of the event, him/herself, circumstances, and the environment [15]. Perception is very individual because each person uniquely interprets a stressful stimulus. Based on this, the subjective experience can be different in the range from daily and simple to difficult experiences such as the occurrence of a permanent disability [14]. The physiological response is caused by the activation of the autonomic nervous system and the hormonal system, which are responsible for controlling and triggering reactions. Catecholamines, cortisol, and other products created during the activation of two separate systems flood the body [16]. A whole series of symptoms of the organism's excitement occurs such as rapid heart rate, rapid breathing, trembling and sweaty palms, and facial redness. Behavioral response implies the expression of emotions. It can include crying, shouting, sighing, laughing, grimacing, and gesticulating, but many other reactions depend on the person's personality and social norms [14]. Behavioral responses make it possible to express one's own emotions and declare them to others. Suppression of behavioral responses and emotions can cause serious difficulties in a person's physical and psychological health and functioning. Because of that, the verbalization of feelings is stresnu percepciju. Ukoliko izostane podrška okoline, utoliko će proces suočavanja i/ili prilagodbe bit otežan ili onemogućen. Uz navedeno, tjelesni invaliditet prate i drugi stresni podražaji koji znatno pojačavaju stresnu percepciju i otežavaju proces suočavanja [10]. Primjerice, nepredvidiv tijek tjelesnog invaliditeta i općenito neizvjesnost zdravstvenog stanja često pogoduju tomu da osobe s tjelesnim invaliditetom ne uspiju razviti zdrave mehanizme suočavanja. Nadalje, nedostatne i nepotpune informacije koje se odnose na prognozu invaliditeta dodatno pojačavaju strah od budućnosti, neizvjesnost i osjećaj bespomoćnosti. Nerijetko je odluke potrebno donijeti brzo, posebice one koje se odnose na tretmane i vremensko definiranje istih, što predstavlja dodatni stresni podražaj. Javlja se osjećaj napetosti, konfuzija mišljenja i strah od donošenja odluke s lošim posljedicama. Zbog nepredvidivosti tijeka bolesti i nedostatnih informacija, može doći do gubitka povjerenja, osjećaja nesigurnosti i dvosmislenosti, preispitivanja točnosti dijagnoze i posljedično tomu, odgađanja ponuđenih tretmana liječenja i rehabilitacije. Navedeno može dovesti do gubitka dragocjenog vremena i dodatno pogoršati teške zdravstvene okolnosti. Naime, rana rehabilitacija iznimno je značajna ne samo za ponovnu uspostavu fizičke snage i sposobnosti nego i radi prekidanja samodestruktivnih misaonih procesa te omogućavanja pozitivnog emocionalnog napretka u suočavanju s invaliditetom koji mijenja život [18]. Osim toga, znatan broj osoba s tjelesnim invaliditetom, a posebno osobe u njihovu okruženju, nema značajnijeg iskustva u suočavanju s pojavom tjelesnog ili bilo kojeg drugog invaliditeta. Osobe nema spoznaju kako se nositi s iznenadnom pojavom tjelesnog invaliditeta i/ili pogoršanjem već prisutnog. Kao takav, nedostatak iskustva znatno utječe na načine reagiranja, proces suočavanja i prilagodbu [10].

Emocionalne potrebe kod osoba s tjelesnim invaliditetom

Pojava tjelesnog invaliditeta uzrokuje snažne emocionalne reakcije. Taj složeni obrazac individualnih reakcija vezuje se za nastalu okolnost, osobe, stvari i situacije koje pojedinac percipira važnima. Odgovor je različit od osobe do osobe, stoga definiranje emocija nije uvijek sasvim jednoznačno [13]. Moguće ih je definirati kao unutarnju reakciju pojedinca na impulse različitog intenziteta koji dolaze iz okruženja [14]. Međutim, bilo kakvo jasnije specificiranje emocija izaziva različite kontroverze među znanstvenicima [13]. Ipak, emocije i njihova uloga od neprocjenjiva su značaja u procesu adaptacije na novonastalo stanje.

Emocije doprinose uspostavi i održavanju kooperativnih i skladnih odnosa. Usko su povezane s afilijativnim potrebama. Polazište afilijativnih potreba determinirano je postavkom da svako ljudsko biće treba druge ljude kako bi ostvarilo potrebu za pripadanjem, altruizmom, suradnjom, samoostvarenjem i komunikacijom s drugima [13]. Kod karakterizacije emocionalnih potreba osobe s tjelesnim invaliditetom valja istaknuti da se emocije promatraju i u kontekstu društvenih odnosa. Nastavno tomu, treba ih promatrati kao osnovu ponašanja u okruženju kojemu osoba pripada. Širok je raspon takvih oblika emocija, od onih pripadnih samoj osobi (osjećaj tuge, straha, srama, krivnje) do onih koje

essential in the process of adaptation, acceptance of disability, and the emotional life of a person in general. Also, the regulation of emotions as an individual's attempt to influence his own emotions and the emotions of others represents another segment that contributes to the stability of a person and the definition of emotional needs [17].

Change in one's self-image, identity, roles and relationships, living environment, and perception of the future further increases the stressful perception. If there is no support from the environment, the process of coping and/or adaptation will be difficult or impossible. In addition to the aforementioned physical disability, other stressful stimuli significantly increase stress perception and make the coping process more difficult [10]. For example, the unpredictable course of physical disability and the general uncertainty of the health condition often favor the fact that people with physical disabilities fail to develop healthy coping mechanisms. Furthermore, insufficient and incomplete information related to the prognosis of disability further increases fears for the future, uncertainty, and feelings of helplessness. Decisions often need to be made quickly, especially those related to treatments and timing, which is an additional stressful stimulus. There is a feeling of tension, confusion of opinion, and fear of making the wrong decision resulting in negative consequences. Due to the unpredictability of the course of the disease and insufficient information, there may be a loss of trust, a feeling of uncertainty and ambiguity, a questioning of the accuracy of the diagnosis, and, consequently, a delay in the offered treatment and rehabilitation. This can lead to the loss of valuable time and further aggravate the difficult health condition. Namely, early rehabilitation is crucial not only for the re-establishment of physical strength and abilities but also to interrupt self-destructive thought processes and enable positive emotional progress in dealing with life-changing disabilities [18]. In addition, a significant number of people with physical disabilities, and especially people in their environment, do not have significant experience in dealing with the appearance of a physical or any other disability. The person does not know how to deal with the sudden appearance of a physical disability and/or the worsening of an already present one. As such, the lack of experience significantly affects the ways of responding, the coping process, and adaptation [10].

Emotional needs of people with physical disabilities

The appearance of a physical disability causes strong emotional reactions. This complex pattern of individual reactions is related to the circumstances, people, things, and situations the individual perceives as important. The answer is different from person to person, so the definition of emotions is not always completely unambiguous [13]. It is possible to define them as an individual's internal reaction to impulses of different intensities coming from the environment [14]. However, any clearer specification of emotions causes various controversies among scientists [13]. Nevertheless, emotions and their role are invaluable in the process of adaptation to the newly created situation.

Emotions contribute to the establishment and maintenance of cooperative and harmonious relationships. They are closely related to affiliative needs. The starting point of affiliatisu blisko povezane s društvenim okruženjem (divljenje, poštovanje, prezir, zavist) [13].

Okruženje u kojem osoba s tjelesnim invaliditetom živi predstavlja objektivnu stvarnost koja nastoji održati u ravnoteži dva osnovna sustava vrijednosti i percepcije – sustav osoba u okruženju i sustav osobe s tjelesnim invaliditetom. Okruženje u kojem osoba s tjelesnim invaliditetom ostvaruje sve svoje potencijale unatoč invaliditetu smatra se stimulativnim i poželjnim za samoispunjenje osobe. Emocionalni je život kompleksan dinamični sustav koji je u stalnoj interakciji s okolinom u kojoj osoba s invaliditetom živi. U toj interakciji osnovni je cilj zadovoljiti vlastite osnovne ljudske potrebe. U situacijama kada osoba to nije u mogućnosti, moguće je narušavanje emocionalne ravnoteže, gubitak zadovoljstva, pojavnost negativnih emocija što sve znatno može narušiti mentalno zdravlje osobe [13].

Emocionalne potrebe osoba s tjelesnim invaliditetom mogu biti dodatno ugrožene zbog neprihvaćanja vlastitog invaliditeta, nedostatne podrške okoline, stigmatizacije, diskriminacije i percepcije društva [19]. Nezadovoljene emocionalne potrebe poput potrebe za emocionalnim povezivanjem, pripadanjem, pažnjom, odlučivanjem, samopoštovanjem, samoostvarenjem i značajem u okolini, uz stalno prisutan percipirani stres, psihološku napetost, snažan osjećaj gubitka zdravlja, istaknutu anksioznost i izostanak podrške, mogu eskalirati u snažne afektivne reakcije [15]. Zato sve emocije i emocionalne reakcije trebaju biti na vrijeme prepoznate. To je važno jer snažna povezanost tjelesnog invaliditeta i narušenog psihološkog zdravlja može pojačati negativne emocije, odraziti se na proces adaptacije i potaknuti progresiju invaliditeta u hendikep. Nadalje, nezadovoljene emocionalne potrebe uz svakodnevni stres mogu negativno djelovati na razvoj loših životnih navika poput tjelesne neaktivnosti, nehigijene spavanja, pušenja i konzumacije alkohola te tako potaknuti dodatne somatske reakcije i neizravno utjecati na tjelesno zdravlje.

Pravovremenim sustavima podrške moguće je prevenirati stanja vezana za stresnu percepciju, pozitivno utjecati na mentalno zdravlje osoba s invaliditetom i poboljšati kvalitetu njihova života [9]. Svi čimbenici koji utječu na deficit u zadovoljavanju osnovnih ljudskih potreba i negativno se odražavaju na emocionalni život osobe s tjelesnim invaliditetom važni su za medicinske sestre u svim fazama procesa zdravstvene njege, a sve u svrhu postizanja emocionalnog zadovoljstva i optimalne kvalitete života osoba s invaliditetom. Studije potvrđuju da stavovi medicinskih sestara doprinose pružanju kvalitetnije skrbi za osobe s tjelesnim invaliditetom [20 – 22]self-image and rehabilitation outcomes. Design: Descriptive cross-sectional survey. Methods: Nursing, Social Work and Medicine students (N = 1007, 79.4% female.

Proces emocionalnog suočavanja s pojavom tjelesnog invaliditeta

Suočavanje predstavlja proces upravljanja i kontroliranja stresne situacije koja je uzrokovana stresnim podražajem. U trenutku suočavanja s tjelesnim invaliditetom kao stresnim podražajem, osoba se koristi strategijama suočava-

ve needs is determined by the fact that every human being needs other people to fulfill the needs for belonging, altruism, cooperation, self-realization, and communication with others [13]. When describing the emotional needs of people with a physical disability, it should be emphasized that emotions are also observed in the context of social relationships. Furthermore, they should be viewed as the basis of behavior in the environment to which the person belongs. There is a wide range of such forms of emotions, from those belonging to the person himself (feelings of sadness, fear, shame, guilt) to those closely related to the social environment (admiration, respect, contempt, envy) [13].

The environment in which a person with a physical disability lives represents an objective reality that strives to maintain a balance between two basic systems of values and perceptions - the system of people in the environment and the system of a person with a physical disability. An environment in which a person with a physical disability realizes all their potential despite the disability is considered stimulating and desirable for the person’s self-actualization. Emotional life is a complex dynamic system that is in constant interaction with the environment in which a person with a disability lives. In this interaction, the main goal is to satisfy one’s basic human needs. In situations where a person is unable to do so, it is possible to disrupt the emotional balance, loss of satisfaction, and the appearance of negative emotions, all of which can significantly impair a person’s mental health [13].

The emotional needs of people with physical disabilities can be further threatened due to the non-acceptance of their disability, insufficient support from the environment, stigmatization, discrimination, and society’s perception [19]. Unsatisfied emotional needs, such as the need for emotional connection, belonging, attention, decision-making, self-esteem, self-realization and significance in the environment, along with constantly present perceived stress, psychological tension, a strong sense of loss of health, pronounced anxiety, and lack of support can escalate into strong affective reactions [15]. Because of that all emotions and emotional reactions should be recognized in time. This is important because the strong connection between physical disability and impaired psychological health can increase negative emotions, reflect on the adaptation process and encourage the progression of disability into a handicap. Furthermore, unsatisfied emotional needs, in addition to daily stress, can cause the development of bad lifestyle habits such as physical inactivity, poor sleep hygiene, smoking, and alcohol consumption, and thus stimulate additional somatic reactions and indirectly affect physical health.

Using timely support systems, it is possible to prevent conditions related to stress perception, positively influence the mental health of people with disabilities and improve their quality of life [9]. All factors which may cause a deficit in meeting basic human needs and hurt the emotional life of a person with a physical disability are important for nurses in all phases of the healthcare process, all to achieve emotional satisfaction and optimal quality of life. Studies confirm that nurses` attitudes contribute to the provision of better quality care for people with physical disabilities [20–22]self-image and rehabilitation outcomes. Design: Descriptive cross-sectional survey. Methods: Nursing, Social Work and Medicine students (N = 1007, 79.4% female.

nja u cilju ponovnog uspostavljanja narušene ravnoteže. Čimbenici koji utječu na način suočavanja s tjelesnim invaliditetom višeznačni su. Čimbenici povezani s bolešću ili ozljedom odnose se na pojavnost boli, nepredvidivost, nepoznate tretmane i načine liječenja, promjene izgleda i slično. Osobni i demografski čimbenici uključuju dob, spol, vlastite sposobnosti i mogućnosti nošenja sa stresom, sustav vrijednosti i vjerovanja. Fizički, socijalni i okolinski čimbenici odnose se na podršku okoline, blizinu zdravstvenih ustanova, razumnu prilagodbu, adaptaciju okruženja, uređenost i prilagođenost okoliša [10].

Proces suočavanja odvija se u tri faze: kognitivna procjena, faza prilagodbe i razvijanje strategije suočavanja [10]. Nakon stresne spoznaje o tjelesnom invaliditetu osoba prolazi fazu kognitivne percepcije, analizira okolnosti prije početka invaliditeta te stanje koje se javlja trenutno. Osoba s tjelesnim invaliditetom procjenjuje vlastito zdravstveno stanje i ova se faza smatra kognitivnom procjenom. Procjena ovisi o prethodnom iskustvu osobe, mogućnostima misaonog analiziranja, osobnim uvjerenjima o invaliditetu i podršci koju pruža okolina [10]. Pritom se javljaju različite emocije, a moguće su i afektivne reakcije. Redoslijed javljanja pojedinih emocija nije strogo definiran, već je prisutno njihovo stalno ispreplitanje i pojavnost različitih drugih emocionalnih reakcija. Faza prilagodbe dio je procesa suočavanja koji slijedi nakon kognitivne procjene i emocionalnih reakcija [10]. Prolazeći kroz poricanje (nepriznavanje i osamljivanje), gnjev, cjenjkanje, depresiju, osoba polako osvješćuje realne okolnosti te im se počinje postupno prilagođavati. Međutim, da bi se prilagodba uspješno odvijala i uspješno dovršila, potrebno je suočiti se s određenim adaptivnim zadaćama [10]. Adaptacija i njezine zadaće odnose se na tjelesni invaliditet i općenite okolnosti vezane za pojavnost invaliditeta. Adaptivne zadaće prilagodbe koje se odnose na tjelesni invaliditet obuhvaćaju nošenje s poteškoćama vezanima za tjelesni invaliditet; bolom, nepokretnošću i nesamostalnošću u izvođenju aktivnosti svakodnevnog života. To se odnosi i na suočavanje s tretmanima i terapijskim postupcima, boravcima u zdravstvenim ustanovama te razvoj i održavanje povezanosti sa zdravstvenim radnicima. Cilj je adaptivnih zadaća u prilagodbi održati emocionalnu ravnotežu, osvijestiti vlastite mogućnosti i potaknuti prilagodbu na izmijenjen fizički izgled uzrokovan invaliditetom. Nadalje, održavanje pozitivnih odnosa s članovima obitelji i prijateljima te priprema za neizvjesnu budućnost imaju vrlo važnu ulogu u provođenju općih adaptivnih zadaća [10].

Strategije suočavanja započinju nakon kognitivne procjene i ispunjenih adaptivnih zadaća. U razvijanju strategije osoba se može usmjeriti na problem, emocije i procjenu misaonih procesa kako bi se suočila s različitim aspektima tjelesnog invaliditeta [23]. Na početku, osoba osvješćuje svoje snage, prikuplja dodatne informacije o tjelesnom invaliditetu i novim mogućnostima, sklona je traženju podrške u okolini te time planira i razvija strategiju suočavanja s problemom. Stečena specifična znanja, informacije i vještine nastoji organizirati na način koji će doprinijeti rješavanju ili barem djelomičnom uklanjanju problema koji se vezuju za tjelesni invaliditet [10]. Suočavanje usmjereno na emocije usmjereno je na pokušaje ublažavanja ili smanjivanja emocionalne napetosti i negativnih emocija koje su potaknu-

The process of emotional coping with the appearance of physical disability

Coping is the process of managing and controlling a stressful situation, which is caused by a stressful stimulus. When faced with a physical disability as a stressful stimulus, a person uses coping strategies to re-establish the disturbed balance. The factors that influence the way of coping with a physical disability are multifaceted. The factors related to illness or injury refer to the occurrence of pain, unpredictability, unknown treatments and methods of treatment, changes in appearance, etc.). Personal and demographic factors include age, gender, own abilities and ability to cope with stress, value, and belief system. Physical, social, and environmental factors refer to the support of the environment, the proximity of health institutions, reasonable adaptation, adaptation of the environment, organization, and adaptability of the environment [10].

The coping process takes place in three phases: cognitive assessment, adaptation phase, and developing a coping strategy [10]. After the stressful realization of a physical disability, a person goes through a phase of cognitive perception, analyzing the circumstances before the onset and the current state. A person with a physical disability assesses his state of health, and this phase is considered a cognitive assessment. This assessment depends on the person's previous experience, the possibilities of thought analysis, personal beliefs about disability, and the support provided by the environment [10]. Various emotions appear in this, and affective reactions are also possible. The sequence of occurrence of individual emotions is not strictly defined, but their constant interweaving and the appearance of various other emotional reactions are present. The adjustment phase is part of the coping process that follows cognitive assessment and emotional reactions [10]. Going through denial (non-recognition and isolation), anger, bargaining, and depression, the person slowly becomes aware of the actual circumstances and gradually begins to adapt to them. However, for the adaptation to be completed successfully, it is necessary to face certain adaptive tasks [10]. Adaptation and its tasks refer to physical disability and general circumstances related to the occurrence of disability. Adaptive adjustment tasks related to physical disability include coping with difficulties related to the physical disability: pain, immobility, and lack of independence in performing activities of daily life. That also applies to coping with treatments and therapeutic procedures, staying in healthcare institutions, and developing and maintaining relationships with healthcare professionals. General adaptive tasks in adjustment aim to maintain emotional balance, become aware of one's possibilities and encourage adaptation to the changed physical appearance caused by disability. Furthermore, maintaining positive relationships with family members and friends and preparing for an uncertain future are important in the implementation of general adaptive tasks [10].

Coping strategies begin after cognitive assessment and completed adaptive tasks. In developing a strategy, a person can focus on the problem, emotions, and evaluation of thought processes to deal with different aspects of physical disability [23]. In the beginning, a person becomes aware of his/

te stresnim podražajem, odnosno tjelesnim invaliditetom. Moguće je korištenje različitih metoda i tehnika relaksacije koje mogu doprinijeti smanjenju napetosti i emocionalnoj ravnoteži. Unutar tih mehanizama javlja se emocionalna regulacija kao sposobnost utjecaja na vlastite emocije, prilagođava ih stresnoj situaciji i zahtjevima okoline [17]. Zatim se javlja emocionalno otpuštanje koje uključuje verbalizaciju vlastitih osjećaja, kao i podjelu osobnih emocionalnih iskustava s bliskim osobama u okruženju. Osoba uočava da je potrebno razmotriti mogućnost prihvaćanja nastale situacije [9, 10]. Suočavanje usmjereno na procjenu misaonih procesa podrazumijeva nastojanje osobe da modificira misli povezane s nastalom stresnom situacijom, kao i težnju da promijeni percepciju o njoj. Osoba tada logički analizira problem kako bi ga u potpunosti razumjela i riješila te započinje mentalnu pripremu za upravljanje situacijom. Ubrzo nastupa kognitivna redefinicija koja predstavlja prihvaćanje stvarnosti i stvaranje novog pozitivnog načina funkcioniranja u novonastaloj situaciji [10].

Pojava tjelesnog invaliditeta nije stresna samo za osobu s tjelesnim invaliditetom nego i za druge osobe u njezinu okruženju. Svi oni mogu biti duboko potreseni zbog narušenog zdravstvenog stanja i pojave tjelesnog invaliditeta kod njima drage osobe. Iako u nešto drugačijoj dimenziji, oni na sličan način prolaze emocionalne reakcije, faze tugovanja, razvijanje strategije suočavanja i prihvaćanje novonastale situacije pokušavajući dati svoj doprinos u prilagodbi voljene osobe te i sami trebaju stanovitu razinu podrške [1].

Nakon niza intenzivnih emocija, osoba s tjelesnim invaliditetom i njezina obitelj postupno ulaze u fazu prihvaćanja. Međutim, ova faza procesa suočavanja nije završetak teških trenutaka, nego je početak novog suživota s invaliditetom. Tu je posebno važna snažna podrška osobi i njezinoj obitelji, posebno u onim izazovima koje tjelesni invaliditet stavlja pred njih. Nerijetko emocije imaju tendenciju vraćanja pa osoba treba još snažniju podršku kako bi se održala određena razina kontrole nad situacijom [24]. Iako se tjelesni invaliditet nerijetko percipira kao tragična životna promjena, osobu je uz adekvatnu podršku okoline moguće potaknuti na nove životne izazove i pozitivna ostvarenja.

Zaključak

Suočavanje osobe s pojavom tjelesnog invaliditeta vrlo je kompleksno i zahtijeva multidisciplinaran pristup u kojem suradnja svih članova u timu treba biti na visokoj razini. Psihološka dimenzija tjelesnog invaliditeta ključna je u procesu suočavanja s pojavnošću tjelesnog invaliditeta. Medicinske sestre neposredno su prisutne u svim fazama suočavanja s tjelesnim invaliditetom, dostizanju optimalne razine samostalnosti, razvijanju otpornosti na vanjske pritiske i samoostvarenju osobe. Podrška u suočavanju, prevencija razvoja hendikepa, stigmatizacije i diskriminacije te snažna senzibilizacija javnosti, samo su neke od kompetencija medicinskih sestara u ostvarivanju punog potencijala i inkluzije osoba s tjelesnim invaliditetom u društvo.

Nema sukoba interesa

her strengths, collects additional information about physical disability and new possibilities, tends to seek support in the environment, and plans and develops a strategy for dealing with the problem. Acquired specific knowledge, information, and skills try to be organized in a way that will contribute to solving or at least partially eliminating problems related to physical disability [10]. Emotion-focused coping is focused on attempts to alleviate or reduce emotional tension and negative emotions that are triggered by a stressful stimulus or physical disability. It is possible to use different relaxation methods and techniques that can contribute to reducing tension and emotional balance. Within these mechanisms, emotional regulation appears as the ability to influence one's own emotions and adapt them to stressful situations and the demands of the environment [17. Then there is emotional release, which includes verbalizing one's feelings, as well as sharing personal emotional experiences with close people in the environment. The person notices that it is necessary to consider the possibility of accepting the situation [9,10]. Coping aimed at evaluating thought processes implies a person's effort to modify the thoughts associated with the stressful situation and the aspiration to change the perception of it. In doing so, the person logically analyzes the problem to fully understand and solve it and begins mental preparation for managing the situation. Cognitive redefinition soon follows, which represents the acceptance of reality and the creation of a new positive way of functioning in the newly created situation [10].

The appearance of a physical disability is not only stressful for a person with a physical disability but also for other people in their environment. All of them can be deeply agitated by the impaired health condition and physical disability of their loved ones. Although in a slightly different dimension, they similarly go through emotional reactions, stages of grieving, developing a coping strategy and accepting the newly created situation, trying to contribute to the adjustment of a loved one, and they require a certain level of support [1].

After a series of intense emotions, the person with a physical disability and their family gradually enter the phase of acceptance. However, this phase of the coping process is not the end of difficult moments, but the beginning of a new coexistence with disability. At the same time, strong support for the person and his/her family is of exceptional importance, especially in those challenges that physical disability puts before them. Emotions often tend to return, so the person needs even stronger support to maintain a certain level of control over the situation [24]. Although physical disability is often perceived as a tragic life change, with adequate support from the environment, a person can be encouraged to new life challenges and positive achievements.

Conclusion

Dealing with a person with a physical disability is very complex and requires a multidisciplinary approach in which the cooperation of all team members should be at an enviable level. The psychological dimension of physical disability is crucial in the process of dealing with the occurrence of physical disability. Nurses are directly present in all phases of dealing with physical disabilities, reaching the optimal level of independence, developing resistance to external pressures, and self-realization of a person. Coping support, prevention of the development of handicaps, stigmatization, and discrimination, and strong public awareness are just some of the competencies of nurses in reaching their full potential and the inclusion of people with physical disabilities in society.

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Literatura/References

[1] Ljubičić, M. *Zdravstvena Njega Osoba s Invaliditetom*; Sveučilište u Zadru: Zadar, 2014;

[2] Sehat, Z.; Fakharian, E.; Sehat, M.; Omidi, A. Disability and Post-Trauma Stress in the Population over 15 Years Old in Kashan, Iran: A Population-Based Study. *Chinese J. Traumatol.* 2020, *23*, 351, doi:10.1016/J.CJTEE.2020.09.004.

[3] Terrill, A. L.; Molton, I. R. Frequency and Impact of Midlife Stressors among Men and Women with Physical Disability. *Disabil. Rehabil.* 2019, *41*, 1760–1767, doi:10.1080/09638288.2018.1448466.

[4] Hughes, R. B.; Taylor, H.B.; Robinson-Whelen, S.; Nosek, M.A. Stress and Women with Physical Disabilities: Identifying Correlates. *Womens. Health Issues* 2005, *15*, 14–20, doi:10.1016/J.WHI.2004.09.001.

[5] Leutar, Z.; Štambuk, A. Stavovi Mladih Prema Osobama s Tjelesnim Invaliditetom. *Rev. Sociol.* 2006, *37*, 91–102.

[6] World Health Organization *World Report on Disability*; World Health Organization: Geneva, 2011; ISBN 9789241564182.

[7] Rulnjević, N.; Strnad, M.; Komadina, D.; Crlenjak, V.; (prev.) *Međunarodna Klasifikacija Oštećenja, Invaliditeta i Hendikepa*; Zavod za zaštitu zdravlja Hrvatske: Zagreb, 1986.

[8] Reeve, D. Psycho-Emotional Dimensions of Disability and the Social Model. In *Barnes C and Mercer G. (eds) Implementing the Social Model of Disability: Theory and Research*; The Disability Press: Leeds, 2004; pp. 83–100.

[9] Havelka, M. *Zdravstvena Psihologija (Nastavni Tekstovi)*; Zdravstveno veleučilište Zagreb: Zagreb, 2002.

[10] Ogden, J. *Health Psichology: A Textbook*; Open University Press: New York, 2007; ISBN 978-033522263-6.

[11] Pérez-Garín, D.; Recio, P.; Silván-Ferrero, P.; Nouvilas, E.; Fuster-Ruiz de Apodaca, M.J. How to Cope with Disabilities: Development and Psychometric Properties of the Coping With Disability Difficulties Scale (CDDS). *Rehabil. Psychol.* 2020, *65*, 31–44, doi:10.1037/REP0000293.

[12] Byra, S.; Ćwirynkało, K. Coping Strategies in Students with Physical Disabilities – Predictive Role of Self-Esteem, General Self-Efficacy and Basic Hope. *Hrvat. Rev. za Rehabil. istraživanja* 2018, *54*, 1–11, doi:10.31299/HRRI.54.2.1.

[13] Hanková, M.; Vávrová, S. Emotional and Social Needs of Integrated Disabled Students in Secondary School Environment. *Procedia - Soc. Behav. Sci.* 2016, *217*, 229–238, doi:10.1016/J.SBSPRO.2016.02.073.

[14] UWA Online *The Science of Emotion: Exploring the Basics of Emotional Psychology*; Dostupno na: https://online.uwa.edu/news/emotional-psychology/ Datum pristupa informaciji: 2. 9.2021.

[15] Ljubičić, M. *Palijativna Zdravstvena Njega*; Naklad Slap: Jastrebarsko, 2020;

[16] Guyton, A. C.; John E. Hall *Fiziologija*; Andreis, I., Taradi, S.K., Taradi, M., Eds.; Medicinska Naklada: Zagreb, 2017.

[17] McRae, K.; Gross, J.J. Emotion Regulation. *Emotion* 2020, *20*, 1–9, doi:10.1037/EMO0000703.

[18] Kurz, A. E.; Saint-Louis, N.; Burke, J.P.; Stineman, M.G. Exploring the Personal Reality of Disability and Recovery: A Tool for Empowering the Rehabilitation Process. *Qual. Health Res.* 2008, *18*, 90, doi:10.1177/1049732307309006.

[19] Baker, W.; Namavar, R. *9 Basic Emotional Needs Everyone Has & How To Meet Them*; Dostupno na: https://www.mindbodygreen.com/articles/9-emotional-needs-according-to-maslow-s-hierarchy Datum pristupa informaciji: 2. 9.2021.

[20] Kritsotakis, G.; Galanis, P.; Papastefanakis, E.; Meidani, F.; Philalithis, A.E.; Kalokairinou, A.; Sourtzi, P. Attitudes towards People with Physical or Intellectual Disabilities among Nursing, Social Work and Medical Students. *J. Clin. Nurs.* 2017, *26*, 4951–4963, doi:10.1111/JOCN.13988.

[21] Ruiz, P. O.; Gonzalez-Medina, G.; Couso, A. S.; Palomares, M. J.; Mansilla, J. R.; Ardila, E. M. G.; Vicente, M. N. M. Attitude towards People with Disability of Nursing and Physiotherapy Students. *Children* 2020, *7*, doi:10.3390/CHILDREN7100191.

[22] Ljubičić, M.; Šare, S.; Bratović, N. Stavovi Medicinskih Sestara Prema Osobama s Invaliditetom. *Sestrin. Glas.* 2015, *20*, 33–41, doi:10.11608/sgnj.2015.20.007.

[23] Kara, B.; Açıkel, C. H. Predictors of Coping in a Group of Turkish Patients with Physical Disability. *J. Clin. Nurs.* 2012, *21*, 983–993, doi:10.1111/J.1365-2702.2011.03890.X.

[24] Kübler-Ross, E. *Razgovori s Umirućima*; Biblioteka Oko 3 ujutro: Zagreb, 1989;