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THE ROLE OF INTEGRATED PSYCHOLOGICAL KINETO RECOVERY IN THE POST OF AVC PATHOLOGY

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Abstract

The paper lays emphasis on the importance of linking the methods of kinetic recovery techniques and the specific methods of psychological consoling, which holds the purpose of complex rehabilitation of the patient with stroke both physical /mental and emotional , lowering the negative impact of depression linked to after stroke depression.

Beginning: Stroke means a fast lost of the brain function because of the problems that occur in brains' blood flow. The history may be either ischemic – missing the blood flow caused by a block of brain blood (thrombosis, arterial embolism). Ischemic stroke or blood stroke is a cause of a brake of blood vessel or of an average blood structure- blood stroke.

Prevalence: In Europe around 1 million deaths each year come because of stroke 20-30% of the patients die during the first month and about 75% from the survivors develop disabilities and loose their independence. In Romania 21,64% of the death caused by stroke being the second death cause and the second disability cause 11,34%.

National Statistics' Institute believe that a growth of mortality cause by stroke to 35% until 2035 having the data that after the age of 65 the values grow 10 times and the average age of beginning is 37.

Keywords: kinetic recovery, depression, psychological consoling

Introduction

Stroke affects patients' physical, functional, emotional, the consequences differ on dimension and place where the brake took place.

"Somatic paralysis, paralysis, decubitus, pneumonia, urinary incontinence and, implicitly, personal autonomy are reduced. The place and role of the patient both in family and in society changes" (Caplan L.R,, Hon F.K.S. (2004).

"Psychological level the modification on emotions brought by the direct brake of emotional centers in the brain cause disorders at the level first of all cognitive, mnesic, prosexice, language, and on the other side the difficulty to adapt to the new boundaries which came along with this sickness align the emotional mood to about 50% of the patients who suffered stroke" (American Psychiatric Association, 1994).

The field research reveal the fact that all emotional manifestation came gradual appear at the early beginning by doubt, revolt, powerless, negativity, catastrophe, modification of self esteem "what have I been and how have I become". Another set of traumatizing modification felt by the patient who suffered stroke are linked to role and status. By changing the role and place both in family and in society the loose or change of job, the modification brought in sexual relational bring a major impact on the patients' recovery (Lucaci P., Necuăeș M., 2015).

"The impact is even bigger when stroke begins at an early age. All this mixture of feelings modifies the inner value system held by the individual and develops a form of depression. The depression after stroke has a prevalence of around 35-50% and begins after 3-6 months after the blood event, period I which the kinetic recovery can be affected and the progress diminished.

The person affected manifests a lack of interest to outer world, lowering energy level, and feels as if the entire world clashed over him/her" (Johnston S.C. et al., 2009).

"The recovery after stroke is a complex and multidisciplinary process. It involves collaboration and a complex team of experts, doctors, physiotherapists, psychologists and occupational therapists. And last but not least the family should offer the emotional support and psychological therapy for determining the new adapting process imposed by the patients' illness" (Khandelwal P. et al., 2016).

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Psychological level, all the modification of thinking level need a sustained therapy and it is important that the recovery process at kinetic level to be linked to psychological therapy during all stages because during all levels at each and every one of them involves effort, will, assumption and awareness. The patient must recreate a new identity in which he/she should get use to accepting and valuing himself/herself (Holdevici I., 1997).

The objectives set out in the psychological plan imply (Andersen K.K. et al., 2009)**:**

- Understanding the neurophysiological mechanisms that produced stroke;
- Changing cognitions by defining personal goals;
- Information and awareness;
- Taking responsibility;
- Identification of motivational and affective resources;

The established goals are adapted to the patient's attitudes, socioprofessional level, personal pathological antecedents.

From a psychological point of view, cognitive behavioral therapy fills most effectively with the patient's needs because it focuses the patient's attention on the present and the situation they are in. It will help to identify negative thoughts, thought errors, change behavior and, implicitly, mood.
The patient will be taught to think adaptively, to improve their affective feelings, which will increase motivation.
The main theoretical trends in cognitive behavioral therapy are: "Cognitive Model of Aaron Beck" and "Albert Ellis Cognitive Model" (Bancroft J., Graham C., 1998).

„Cognitive Model of Aaron Beck"

The essential concepts of Aaron Beck's model are automatic thoughts, cognitive distortions and cognitive schemes (Daniel D., 2006).

a. Automatic gags

These are the thoughts that occur involuntarily and automatically when a person is in a certain situation. For example, a patient during a decinetotherapy session, following repeated exercises, looks into the mirror and in his mind the following thoughts may arise: “I'll never recover, I'm a loser, I'm incompetent, I'm disabled now, I have no chance”. These automatic thoughts are grouped into cognitive schemes that have a higher degree of generality. These thoughts may occur at any time during the recovery process, depending on the individual cognitive pattern and the area in which the patient activated before stroke occurs.

A cognitive scheme such as "I am incompetent" and is manifested in several areas of her life that refer to performance.

b. Cognitive schemes

Cognitive schemes are the basic beliefs that people have about themselves, the world and others. Two types of cognitive schemes are known: adaptive and non-adaptive. Certain cognitive disadaptive schemes are predictable for emotional and behavioral changes. For example, a person who develops a mild form of depression, and who, in the recovery room, is observed to look first worried around, with an aura of helplessness and painstaking painted on the face, will have the schema: "I do not want to do nothing good! I'm not in the mood! I will never recover!”.

c. Cognitive Disorders

Cognitive distortions or thinking errors are: overgeneration, maximizing or minimizing the importance of events, personalization, thinking of the "all or nothing" type, leaping to conclusions.

Through therapy, the patient will be taught and helped to understand the neurophysiological mechanisms that produced stroke; It will define viable, achievable personal goals, will be assumed in terms of changing the

role in the family and in interpersonal relationships, and after the interview and observation will be helped to identify motivational and implicitly affective resources.

„It is important to be aware by the therapeutic team that each patient is different in his personality structure and in the pathology overlaid by the disease of the personal pathological antecedents, and that each therapy will be adapted and personalized to the patient" (Sbenche T., 1987).

If a patient with stroke pathway is recruited into a cognitive behavioral therapy session, segmented in meetings, complicated in the motor recovery process, we will have at discharge, a recovered patient both physically and emotionally, reintegrated into the family, returned to the company.

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