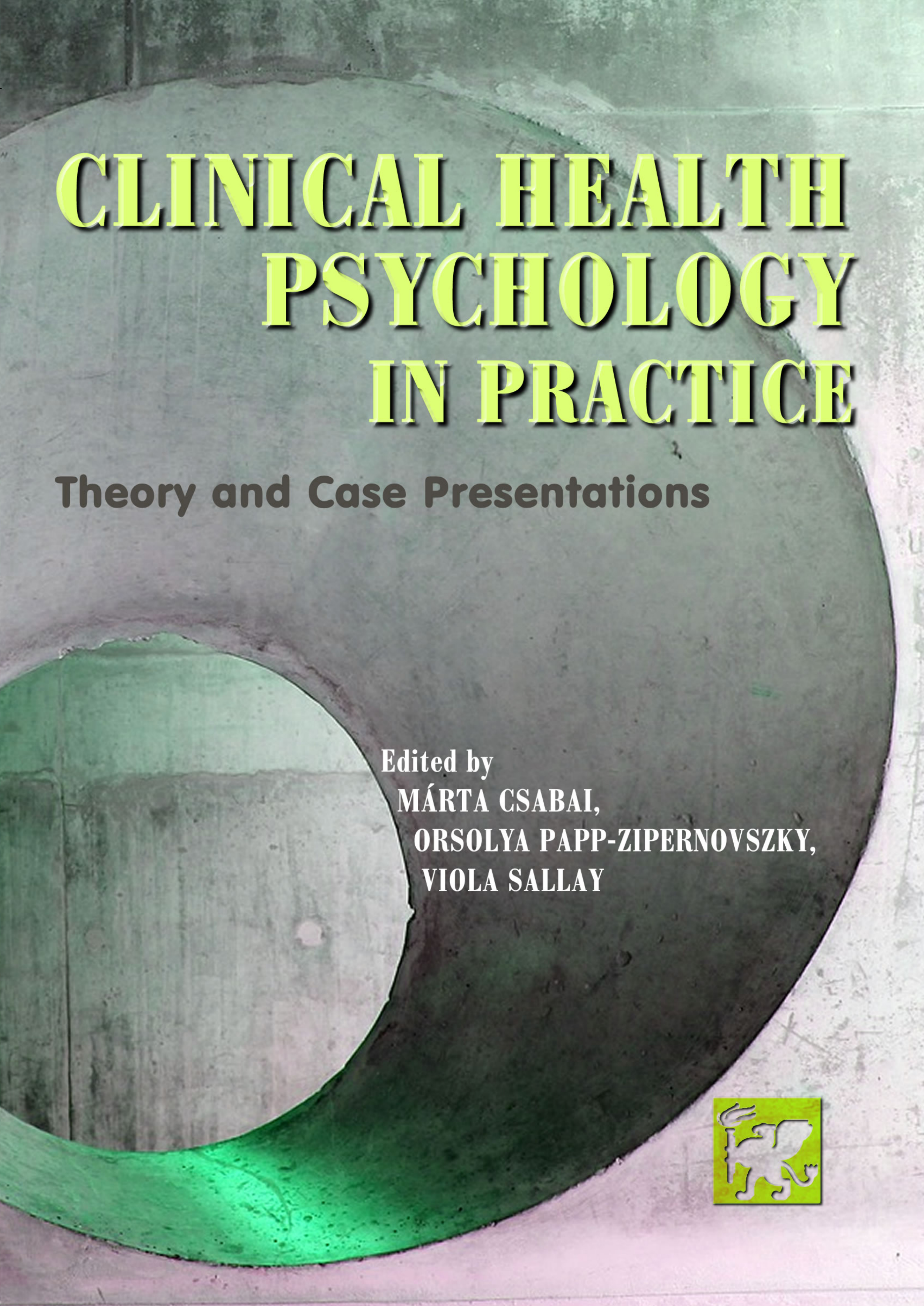

CLINICAL HEALTH PSYCHOLOGY IN PRACTICE

Theory and Case Presentations

Edited by
MÁRTA CSABAI,
ORSOLYA PAPP-ZIPERNOVSZKY,
VIOLA SALLAY

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FOREWORD

Health psychology has become an independent and attractive discipline in the last fortysome years. During this time, clinical psychologists, social psychologists, and experts from other fields have drawn on theoretical and practical approaches from medical and clinical psychology, public health, medical anthropology, sociology, and psychosomatic medicine to develop a unified discipline focused on the preservation, development or improvement of health, well-being and quality of life (Friedman & Adler, 2007; Urbán, 2017). Health psychology has made it possible to apply the knowledge and methods of psychology to the prevention, detection, and rehabilitation of physical illnesses, in addition to the recognition, classification and treatment of disorders of mental functioning. Although the role of psychological factors in the development of diseases and in their treatment has been well known since antiquity, biomedical medicine temporarily ousted it from medical thinking. The biopsychosocial approach, in response to realising the limitations of the biomedical approach, opened the way to examine the role of behavior, thinking and emotions again.

The international development of health psychology has been closely followed by Hungarian practitioners, as documented by a series of Hungarian textbooks and manuals (e.g. Kulcsár, 1998; Kállai et al., 2007; Csabai & Molnár, 2009; Demetrovics et al., 2012; Urbán, 2017). The present, comprehensive volume follows in their footsteps, however goes further by placing a special emphasis on the coordination of theory, research and practice. In this respect, this volume is predestined to evoke attention among the highly regarded handbooks on the international scene.

The book provides a thorough insight into clinical health psychology, a field of health psychology. The domestic development of clinical health psychology, also known as applied health psychology, follows as well as drives on the domestic trend to recognize and to employ specialized experts in almost all areas of medicine who are skilled in the psychological aspects of medicine and healing, in order to increase the effectiveness of care and patient satisfaction. Practicing psychologists present both their state-of-the-art knowledge of their respective medical field and offer insights into their everyday work by presenting case studies in this volume. Each chapter is characterized by a complex approach that considers the emotional, cognitive, motivational, and behavioral aspects relevant to the field. Therefore, the chapters undertake to integrate a cognitive-behavioral and psychodynamic approach. While the former focuses more on illness-related thinking problems (e.g. catastrophizing) or illness-related representations, beliefs and how to adaptively rework them to cope more effectively, while the latter seeks to explore and address the emotional meaning of illness, the existential losses, fears, anxieties and imbalances that illnesses trigger.

The present volume displays an essentially positive approach, reflecting the optimism that there is always room for the possibility of using psychological methods such as psychoeducation, supportive presence, emotion validation, behavior change promoting motivational and self-control methods, and cognitive and behavioral therapy methods to reduce the suffering associated with illness and improve the quality of life. However, this practical work could not have been carried out without up-to-date knowledge of research and effectiveness studies in the field in the first place, as well as an awareness of the patient's expectations, preferences, and potential, while it definitely must be aware of its own competences and limitations. The chapters in this volume explicitly reflect all three aspects.

This excellent volume on clinical health psychology, also known as applied health psychology, is a major and important undertaking which will satisfy for many years the interests of both university students and practicing psychologists, as well as other health professionals and doctors. Although the volume is essentially a textbook, it should be of interest to those involved in the subject in any way. It also plays an important role in facilitating dialogue between different professionals and helping to ensure that the methods and approaches offered by psychologists are used more often to help the work of health professionals and doctors and ultimately to benefit patients and their relatives; in other words all of us.

Budapest, January 9, 2022.

Róbert Urbán
University Professor, Doctor of the Hungarian Academy of Sciences

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EDITORIAL FOREWORD

This volume, which we are launching with great joy and anticipation, presents the emergence and achievements of applied health psychology (clinical health psychology) in relation to important milestones in its history in Hungary.

As a result of a decade-long professional development work, research, training and care organization efforts, health psychologists are able to carry out their activities within a stable professional framework today. In 2013, postgraduate training in applied health psychology was launched in Hungary by a government resolution, and gradually, this professional activity became accepted and institutionalized.

An increasing number of excellent professionals have been working within this framework. Learning about their professional work can support the training and activity of the next generations of health psychologists. Therefore, we found it necessary to compile a case-oriented handbook which is based on the everyday experience of health psychologists in practice and presents their work and methods. Accordingly, our volume reviews the fields of applied health psychology, the work of health psychologists, their methods, practical experiences, and the national and international state of the field.

The authors and editors of the volume are members of the Szeged Health Psychology Workshop, a professional community of graduates, trainees, and teachers of the Applied Health Psychology postgraduate program at the University of Szeged. The name of the city “Szeged” here refers primarily to the location of the training and the care developments, which were first initiated at the Clinical Centre of the University of Szeged and were then also established in many other institutions in the country.

The studies in this volume provide a comprehensive overview of the applications of health psychology and about the practice, challenges, and evidence-based theoretical background of patient care. The chapters division matches areas of care (Primary Care, Pediatric Care, Women's Health; Surgical, Cardiological and Conservative Care), but we also present the diversity of care modalities (systems approach, prevention, bedside work, private consultation).

The majority of the chapters are based on case studies, providing a subtle presentation of the work of health psychologists working in different areas of patient care.

Each chapter is structured as follows:

1. A broad introduction to the field, drawing on the literature and the writers’s personal experience.
2. A detailed description/analysis of a case or a problem situation from the health psychology perspective (health-disease representations, resources, coping strategies,

peer support, communication skills, health literacy, family and/or institutional environment, communication challenges, purpose of the intervention, description of the therapeutic process, tests and questionnaires used).

3. What general issues or problems are brought into focus by the case/situation/topic presented? What are the challenges and opportunities for improvement in the field?

A few remarks of self-reflection are added towards the end under the motto "What has this case/practical experience taught me?"

The above structure was not rigidly enforced, though, the significance they represent within each chapter has always determined by the author(s) and the topic discussed. We hope that this study volume will be useful for MA and postgraduate courses in health psychology and other health science courses at universities as well as also being useful to psychologists working in patient care and health promotion. More broadly, it supports health professionals and those interested in the subject to situate health psychology within the care system and to work more effectively together in line with today's modern, integrative approach to care.

The volume is therefore warmly recommended to all those interested in the clinical practice of health psychology, especially to professionals working in the field or in training. We hope that we have been able to produce a book that provides a comprehensive overview of our work and the achievements of recent years, and that it will be of use to those in professional training, to students of psychology, medicine, and health science, and to colleagues working in different fields.

Szeged, March 8, 2022.

The Editors

Part 1

PRIMARY CARE
AND CONSERVATIVE TREATMENT

Nóra Szívós

HEALTH PSYCHOLOGY WORK IN PRIMARY CARE

DOI: 10.14232/sztep.chpp.2022.1

1. INTRODUCTION

Primary care is probably one of the unavoidable areas of the healing activities by applied health psychologists, but so far little attention has been paid to the field. According to Kovács and Mészáros (2006), every tenth person who visits his/her GP suffers from psychological symptoms. These patients typically report to their GP a variety of physical symptoms, which have been proven to be the reason behind or accompanying a psychological problem. The lack of time and the predominantly somatic approach of the doctor make it significantly difficult to recognize these problems (Torzsa et al., 2017). Surely, this can also contribute to the fact that the focus of the healing work of many GPs is not on disease prevention, but on patient care. Psychological healing work and the recognition of psychological problems in physical symptoms are primarily the task and competence of psychologists, but integrated mutual work is also needed to understand the complex process of symptoms emerging and to cure them.

As a typical trend in European countries, the development of primary care activities is moving towards a preventive approach. Experts highlight the important role of prevention and health promotion, which is implemented in close cooperation with the involvement of co-professions related to the medical profession in primary care. Psychologists are also present in primary care in a number of countries, such as the Netherlands, the United Kingdom, Denmark and Finland, making a significant relieve on specialist care (KPMG, 2014).

2. PSYCHOLOGISTS IN PRIMARY CARE: LESSONS LEARNED FROM A HUNGARIAN METHODOLOGICAL DEVELOPMENT

In Hungary, the first program to involve psychologists in primary care was the "Primary care model program utilizing public health care resources with public health focus involving the support of Virtual Care Centres" (*"Az egészségügy forrásainak felhasználásával népegészségügyi fókuszú alapellátás-szervezési modellprogram Virtuális Ellátó Központ támogatásával"*, i.e. Swiss Model Program, supported by the Swiss Contribution Hungary S/H/8/1). This program took place between 2013 and 2017, has increased and complemented the competence of primary care through the cooperation of GPs and other professionals, as well as the assistance of psychologists. The modeling program lasted for nearly 5 years in Northern Hungary and the Northern Great Plain regions, in four practice communities (Jászapáti, Heves, Borsodnádasd, Berettyóújfalu). The communities provided new additional services (health check, lifestyle advice, physiotherapy, dietetics, health psychology counselling, prevention ordering, community health promotion programs) with the involvement of various professionals for the local population (Martos et al., 2017).

Cseh and colleagues (2021) in *Experiences and current affairs of practice community model programmes* describe that a total of 194 practice communities were established in Hungary between 2018 and 2021, based on the operating methodology of the practice communities established during the Swiss Model Program. A total of 72,000 people received psychological counselling during the program. In the summary of their article, the authors claim that the praxis communities are functioning as the cornerstone of the development of primary health care in Hungary. They explain that in the framework of multidisciplinary teamwork the practices, with public and other health departments, are able to implement health promotion and prevention programs by making additional services (e.g. health psychology) available to the population.

3. APPLICATION OF PSYCHODYNAMIC THEORIES IN PRIMARY CARE WORK

One of Michael Balint's main ideas and goals was the practical application of the principles of psychotherapy to everyday medical healing work. Balint linked the appearance of physical symptoms to, among other things, conflicts of object relations, so he applied object relations principles in their treatment (Balint, 1957; Csabai, 2010). In my own work and experiences in the practice of general practitioners and clients, I found that early object relationship patterns and relationships were often recognizable behind the scene, which coincided with those described in the *"psychosomatic integration model"* (Stephanos, 1975).

The first step in our work with clients is the development of the *"primary experiential space"* as described by Balint in the psychosomatic integration model (Balint, 1957). This space is characterized by a secure, predictable relationship for the client, which creates the medium where feelings and thoughts that can be verbalized as our sessions progress. The client can let go of the burdens of trauma through recounting of what has happened and expressing feelings in this safe space. The so-called "flash" created in our cooperation is an emotional connection allowing the client to find a connection between his/her negative feelings and his/her physical symptoms (Balint, 1957). In patients with physical symptoms, the task of the psychologist is therefore not to analytically explore the unconscious, underlying causes of symptoms, but to establish the primary, safe experiential space, an empathetic relationship, where the patient can relive and reinterpret his/her experiences with the creation of *"flash"* and can shape his/her own interpersonal relationships based on the model of a secure relationship with the therapist (Balint & Norell, 1973; Csabai, 2010).

Overall the *"psychosomatic integration model"* and the *"flash technique"* contribute to the understanding and reduction of physical symptoms through the understanding of the patient's subject relationships, which is why they can be used in primary care. However, the process of therapeutic work is much more effective – unlike exploratory, psychoanalytic therapy – through biopsychosocial, complex-approach therapy technique, because it takes a relatively shorter time to achieve decreasing in symptoms and development of a more self-reflective way of life.

4. THE IMPORTANCE OF EXPLORING ILLNESS REPRESENTATIONS

In the 1970s, these psychological researches first began to address the study of individual beliefs about the disease and the issue of cognitive representations related to health. Leventhal and colleagues (1980) described the concept of *illness cognition.* In their opinion, patients would develop implicit disease theories when detecting and evaluating their symptoms. *Illness representations* indicate cognitive representations – derived from perceived symptoms, healing and previous experiences in the field of illnesses – and determine information processing. They play a prominent role in adapting to chronic diseases, in understanding the symptoms that come with it (even at the beginning of the onset of symptoms) and in the degree of willingness to cooperate in the process of treatment (Leventhal et al., 1980). According to Tiringer and colleagues (2007), individual representations influence how an individual becomes an active contributor to his/her own treatment, how he/she perceives the symptoms, how he/she can adapt to them and how he/she fights them. The individual representations also influence the person's psychological and behavioral reactions to symptoms and illness.

5. "I DON'T KNOW WHAT I CAN DO WITH THIS PAIN" – A CASE STUDY FROM THE FIELD OF GP CARE

Judith is 33 years old, working in visual arts as a painter. She was born in a small town in the countryside (the Great Plain) and has been living in Budapest with her husband for 8 years. She comes to see her GP with clinical test results because of stomach and abdominal pains that have existed for a year and a half. The family doctor thinks that her diffuse abdominal complaints may be related to psychological problems. Judit agrees, and after the medical check-up, the doctor accompanies her to my room. According to the recent results, among the tumor markers in Judit's blood samples, C19-9 levels were slightly elevated. It is actually a cancer antigen, the appearance of which may indicate the presence of a malignant tumor. However, it may also show an increase in case of other diseases (e.g. gallstones, pancreatitis, cystic fibrosis or various liver diseases). Small amounts of CA 19-9 can be found in healthy people, too. Judith is currently waiting for an ultrasound scan in 2 months, which will reveal the exact diagnosis. She struggles with her physical pain and insecurity about her condition, which is why her GP decided to involve a psychologist in her treatment.

Judit was sitting in the hallway visibly tormented by the pain of her symptoms. When I saw her, I felt really sorry for her and almost felt her physical pain. I wondered what was causing her physical symptoms, what might be behind her pain, and why she was so desperate while she hadn't got an exact diagnosis yet. Maybe there were gastrointestinal illness cases in her family? I thought that I need to explore her family history extensively in order to be able to reveal the causes of her fears.

Judit is short and has a thin, lean build. Her hair is long and black, which she wears in a tied knot – this is how she wears it during every session. Her face is a little pale. Her posture suggests fear, anxiety, she holds her hands together on her lap, her legs crossed all the time. According to her, she was a little scared of the situation, she had never been to a psychologist before. Nevertheless, the rapport quickly develops, and she begins to talk about her condition. In her opinion, her symptoms may be related to stress. She feels an insurmountable nervousness – she just can't calm down. She says she's mostly afraid of cancer. During our first meeting, she reports that stomach pain also sets her back in her life. It occurs many times that she prefers not to eat at all or skip social meals, simply because she is afraid of the following pain. During holidays, when she could rest more, she was almost asymptomatic, she could enjoy all the programs. The method of mind-shifting has been a proven stress management technique for her, she tried to keep herself busy with leisure programs, work or hobby, but now she feels that this is no longer working, she cannot control her symptoms. She often wakes up at night, she is plagued by disturbing thoughts, she can't sleep. She also reports that her family has had several gastrointestinal illnesses, which makes her fears well-founded. Her mother had previously been diagnosed with ulcers, her father had a thin stomach wall of hereditary origin, and her grandmother had pancreatitis.

At the end of the first interview, we looked at what she wanted to achieve, why she wanted to see a psychologist. In her view, she should take things much more lightly. She's trying strictly to meet up to requirements – her friends and family have already signaled this to her. According to her, she also "chases" her own expectations, often unrealistic ones, in her professional life. She always wants to meet her own too ambitious expectations and cannot let these ideas go. She wants to overcome her anxiety and fears and develop her low stress tolerance. She also asks me, if in the course of our collaboration, an old trauma or unreacted event comes to light, I should let her know because she wants to know what could cause her symptoms. At this point, I think that Judit really wants to heal with all her strength, with the greatest determination and aims to leave her physical pains. However, the question arises in me: what negative life event, what kind of loss is she thinking about, what may be underlying her illness? I think she may have an idea about what's the deep lying reason of her symptoms, but lacks the means to be able to face it.

5.1. START OF THERAPY

Judging from the experience of the first meeting, Judit was obviously motivated to work together. Her physical symptoms make her daily life difficult and she has set several goals for herself. At the end of the first meeting, we decided to have 10 meetings, for which we sign the therapy contract. I declare that I am obliged to keep secrecy, and I wouldn't release any information about our meetings to a third party. I will maintain the consultation with her GP because of her somatic examination results. I also talk about the fact that an important part of collaboration would be to find out about an accurate diagnosis. We need to know or exclude possible organic reasons that could cause physical symptoms, as I would choose psychotherapeutic tools accordingly. With these psychotherapeutic tools, Judit will be able to reduce everyday tension, become more efficient in receiving and processing life events, which can contribute to improve her quality of life and maintaining her health for long-term context also.

Aims:

1. Exploration of illness representations, verbalization of physical sensations
2. Clarifying the client's relationship with herself, increasing self-knowledge
3. Use of an effective stress management method

Devices:

1. Autogenic training (relaxation)
2. Brief Illness Perception Questionnaire (BIPQ)

On the second meeting, I ask how she felt after our first meeting, what thoughts she had. She reports that when she got home, she told her husband she had been referred to a psychologist. She had long been contemplating the idea that it would be worth visiting a specialist considering her symptoms. Her husband supported her in that. She also had previously been recommended for autogenic training and yoga, but at that time she missed those opportunities. She explains that after the first meeting, she had mixed feelings, she felt ambiguity. On the one hand, she was very tense when she arrived at her GP with the results of the blood test and was also extremely tormented by her abdominal symptoms that day. Looking back on the events, now she is able to see her symptoms as having caused by stress. On the other hand, she felt a little relief because she thought she could finally talk to a specialist.

5.2. THE LOSS OF THE FATHER – HELPING THE ENTANGLED GRIEVING PROCESS

Judit tells me that her stomach symptoms emerged about three years ago, after her father's death. At this point, I think that this is most likely the life event that she was referring to earlier. After her father's death, she was very concerned about how the family structure would “stand up”, how the family relationships would be settled, how her mother would handle the situation, nor did she know how to settle it in her own life. She thought time would sort it out, but on All Soul’s Day, she couldn't get out of the car in the cemetery and go to the grave because she was crying so hard. In her hometown her paternal grandmother lives in the same household as her mother. According to her, her grandmother and her mother didn't get along. She describes ongoing tensions between them, where the father used to serve as the “buffer zone”. Judit often felt the tension between her parents because of her grandmother's bullying. She shares with me her memory of when her mother was in the kitchen, her father was in the room, and she didn't hear them talking to each other for days. Then, continuing to remember, she explains that after her father's death, she was very concerned about how her mother could handle the new situation, how she would be able to live with the grandmother. Looking back, she now sees that the initial few months were very difficult, and now she sees peace between them, which in her opinion was depending on her mother' s past. In the beginning, they both had to face the fact that they had lost the most important person in their lives, but they already know how to talk to each other about it. For her, too, the most painful event is the loss of her father. Then her voice breaks, she begins to cry and tells me that her father died suddenly at work, without any warning sign. She starts shaking when we discuss this. At this point in therapy, an unreacted loss has surfaced, and I'd like to know where she is at the moment in working through her grief. I assume that Judit is stuck in the mourning process. In the period following her father's death, her attention was not on herself, but on the development of the relationship between her mother and grandmother, and its impact on her own life. I'm trying to find out who could be Judit's real support in those days, who she could have counted on, and how she feels now in her family. At a few meetings, we talk about her relationship with her father. Based on the memories, a healthy, loving father-daughter relationship appears in front of me. Colorful childhood experiences, a providing young adult, a proud father-daughter dance at her wedding, and finally an unexpected and cruel departure. When we talk about the loss of her father, Judit's feelings are difficult to understand, and she finds it difficult to verbalize them. Then, as our sessions progress, I find that when she talks about her father, recalling her childhood memories brings a smile to her face. As if the sadness and the pain would be overtaken by the loving memories that Judith herself articulates. She explains that the feeling of pain is present every day because of the loss, but by being able to remember and express her feelings about her father, she now feels a good warmth in her heart.

5.3. ILLNESS REPRESENTATIONS, LIFE EVENTS AND SOCIAL RELATIONSHIPS

We have dealt with what she herself thinks about her illness and its background over the course of several meetings. She shares with me that during her college years, she didn't care much about her way of life. She believes her wild college years may have contributed to her symptoms. She says that she partied a lot, often skipped several meals, there were times when she studied until dawn, even though she could have done it during the day. She feels like she has really harmed her health, which she is about to restore. Judit finds it difficult to be alone. In the beginning of her time in college, she felt she couldn't be alone, just by herself. She mentions her friends several times during our meetings. She and her husband socialize with a group of friends, they meet regularly. She reports on good-spirited encounters and programs. Her friends know about her illness and provide her real support. She also explains that she feels difficult to adapt to the constantly changing events around her. She also reports panic symptoms. At the beginning of her symptoms, she was given an anxiolytic and sedative. After reading the leaflet, she became unwell, started to produce several side effects within a short period of time, and her heart rate quickly increased with fear. She told me that when the panic symptoms occurred, her husband calmed her down. She thinks during the graduation and state exam period was the first occasion when she felt a degree of stress that she could not do anything about. During these periods she was often plagued by severe headaches. She has been examined, but they didn't find any bodily symptoms. She now knows that her headache at that time was also due to the nervousness regarding her studies, but she had no way of coping with the stress. She says she set too high goals for herself and couldn't relax due to that. Because of this, she felt very stressed and tense for years. At the moment she and her husband are thinking about buying a house, and the duties around all that also worry her. She considers herself a too tight personality among artists. During her university years, she was often advised to be more relaxed, but she had a strong desire to conform, both to herself and her parents. She says she would like to *"bring home"* the glory to her mother and would find it difficult if something did not go as planned. She feels that if she were to take her tasks a little more lightly, she wouldn't be able to move forward and things wouldn't go ahead in life. She adds that when she feels that way, things aren't going well, things aren't going anywhere inside, then she can't digest. During these periods she feels a cramp in her abdomen, a severe pain. Based on what has been said, I tend to think that since Judit was not able to cope effectively with the changes and stress situations in her life, her physical symptoms increased.

When I ask her how she can describe her pain, she says she feels cramping, compressive pain in her stomach, as if she couldn't digest. *"I don't know what can I do with this pain,"* she says.

She describes feeling uneasy, spastic and compressive in her stomach that she cannot get rid of. Most of the time, she tries to calm herself down with deep breaths and/or start massaging her belly.

The group supervising session reinforced me that one of the aims of our cooperation is to reduce stress, to learn the right stress-management techniques. With the help of the autogenic training method, I help to raise her awareness that she can exercise control over her symptoms and stress levels. The method can also help to develop a vision that is characterized not by convulsive compliance and chasing, but by self-acceptance and calmness. Judit sees a connection between her psychological state and her symptoms, which naturally determines the motivation for our cooperation.

5.4. Presentation of the Applied Interventions, Tests and Tasks

During our sessions I used an abbreviated version of the autogenic training relaxation. Relaxation consisted of exercises of the weighting and then warming of the arms, legs and the whole body, as well as exercises for the warmth of the heart, breathing and abdomen. After the second meeting, we practiced relaxation every time, followed by a meeting. At this time, we discussed the physical sensations experienced during the exercise and asked how well she managed to relax, how she felt during the exercises, what feelings were related to the physical processes. I also asked for home practice, the lessons of which we discussed on the following occasions.

During the first few exercises, Judit reported that conscious attention to her belly, relaxing it and warming her belly were difficult. She felt uncapable of indulging into the exercise much. During the abdominal exercise, she experienced her tension, cramping and the physical pains as usually associated. I tried to reassure her about that. I told her that relaxation is based on practice and the first few times is about getting acquainted with the exercises. From the feeling of tension in the abdomen, it is clear that due to the increased stress, Judit finds it difficult to relax her belly. Her attention is on the tense, cramped sensation. However, as practice progressed and her conscious attention was directed to her body parts, she managed to relax and reduce her tension more and more.

The nine-item Brief Illness Perception Questionnaire (BIPQ) enables the rapid identification and evaluation of cognitive and emotional representations of the illness (Broadbent et al., 2006; Látos et al., 2021).

Judit scored 44 points in the questionnaire, which proves to be a high value. Her replies to the questionnaire items and the final result are entirely in line with what she said. She believes her illness affects her life, but she does not control her daily life and recovery will take a considerable amount of time. She is particularly concerned about her illness and symptoms, which has an emotionally significant effect on her. Because she sees a link between her symptoms and her psychological state, she believes she understands her symptoms. As a cause of her symptoms, she describes herself as stressed and anxious, but in her opinion her previous lifestyle also contributed.

In addition to the Brief Illness Perception Questionnaire, I also used the Spielberger State Trait Anxiety Inventory (STAI) (Spielberger et al., 1970). As I assumed from our meetings, Judit scored very high on the questionnaire. Not only is the level of momentary anxiety due to the situation high, but also the level of propensity for it.

5.5. Progression of Therapy, Improvement of the Client's Condition

Halfway through the planned therapy, Judit reports that with the help of relaxation exercises at home and in the sessions, she can relax herself more and more, her stress level has decreased, and her abdominal complaints and pain are gradually decreasing. With the gradual reduction of pain, the improvement of her quality of life can be felt in everyday life, and this has been cited by her partner. She reported feeling calmer, feeling her whole body wasn't stretched. Her control over her symptoms has been strengthened by relaxation and she felt more confident. She sees that discussing her thoughts about her illness has helped her to actually realize that cramping abdominal pain is in fact a symbol of the convulsive compliance that characterizes her life. She feels that by discussing these thoughts with a specialist and discovering connections, she has freed herself from stress, which has enabled her to exercise more control over her symptoms. In my view, this is mainly due to her calmness, which I signal to her. She incorporated not only relaxation into her daily life, but also yoga, which, according to her, also helped her to develop the current positive state. She experienced that if there is a positive change in her mental state, at the same time her physical complaints and symptoms decrease and then disappear. She also told me about her professional goals that are more exactly set and more realistic. She said she wanted to match the expectations at her workplace. We were at the end of our work together when the ultrasound was scheduled. She feared that a tumor or inflammatory process would be diagnosed by the examination – but the test results were negative. When I asked her about the course and circumstances of the investigation, I noticed that she was calm. She reported that she had gone to the investigation on her own, unaccompanied, and that she had not let fear overwhelm her. As she talks about it, I see peace and balance about her. Her posture is visibly comfortable, suggesting calmness.

I consulted with Judit's GP several times about the progress of work and its results. At the beginning of therapy, Judit asked her GP for antispasmodic medication on a few occasions, but these requests gradually became obsolete. The GP was relieved with the case, because in previous encounters he often saw the patient hopeless and desperate. He welcomed the fact that Judit was able to exercise more control over her symptoms with the help of relaxation, discover a link between her mental state and the onset of her symptoms, her stress level decreased, thus her quality of life improved, and pain and stress no longer complicate her daily life. Her GP summed up our work saying so: *"You have healed her!"*

5.6. CLOSING THE CASE, SUMMARY, CONCLUSION

My client showed repeated physical complaints lacking any organic disease or reason. Her constant worry was typical, her stressed state of mind was due to unexplored trauma and unexpected life events. She has realized that a connection between her psychic condition and her physical symptoms exist, which she managed to make even more aware of during therapy. Physical pain without organic problem significantly impaired her quality of life. She tried to treat her own symptoms (pre-planned schedule for meals, massage), but she was not able to overcome anxiety, nor stress. In the background there was a trauma that had not been worked through, as well as the desire to conform and get forward in life, while feeling the constant worrying, high levels of stress. This condition was greatly enhanced by the antigen found in her blood. Arriving for the ultrasound examination, Judit's stress level decreased significantly as a result of the relaxation she had learned, she was calmer and able to control her symptoms more effectively. As therapy progressed, the chronic symptom began to decrease and then disappear (flash – emotional connection) by exploring and processing psychological factors. Judit had considered visiting a psychologist several times before. At the end of the therapy, summarizing the results of our meetings, she said that in her opinion the well-directed questions highlighted important connections for her. As a result of the non-judgmental empathic communication experienced in the therapeutic relationship (Balint's primary experiential space), she was able to mobilize in herself an internal force that contributed primarily to the reduction and later elimination of her psychic and then physical symptoms.

During our therapy sessions, Judith barely spoke of her husband. She shared some pieces of information and talked about events, but she didn't talk about her marriage, nor about their relationship. During therapy, she did not appear to me in the role of a wife. She mentioned her husband as a supportive partner, but I didn't get any insight into the life of the couple. This made me think. Since she didn't bring this side of her life into therapy, I decided not to ask her about it. However, I had doubts about how she would be able to cope with being on her own while her husband would go abroad. But as Judit started to live a more confident and more balanced life, I am convinced that she will be able to cope with difficult situations in life and unexpected events that would occur in the future.

6. DISCUSSION

When Judith was referred to me by her GP, I was delighted that the doctor recognized the symptoms with which make directing a patient to a psychologist sensible. It was an extremely positive experience for me to see a GP practice where the GP also pays attention to the discovery of psychological factors related to the disease during the course of the treatment.

Until now, psychological services in primary care have only been available for certain periods in Hungary. Therefore, we cannot talk about a working, “well-established” or institutionalized system, where the professional could confidently carry out effective healing work as a stable member of the professional team. Therefore, a psychologist working in a GP practice faces a lot of challenges, problems and tasks requiring new competences in order to cooperate effectively with primary care professionals. A professional who has the opportunity to work in a GP practice can certainly consider him/herself a pioneer in this field. He/she must clearly see the responsibility of this work as a contribution to the development and awareness-raising of primary care. The fact that a psychologist has to cooperate with the employees of the general practice professionally, but as a member of a working group, share and receive information, and conduct continuous consultations with medical colleagues – this only partially determines the success of your work. It is important that the psychologist is able to achieve his/her own esteem, to represent authentically all the knowledge through which he/she can provide a higher level of additional service to the given practice community (e.g. patients, doctors, relatives), for which the doctor must also have sufficient openness. They should be able to transcend the biomedical concept, to be willing to work with a psychologist, to protect his/her own and other colleagues' mental health, and to be motivated to provide complex and cost-effective care. There are many tools available to the psychologist on how to shape the attitude of professionals working in the practice. For example, you can provide training for GPs working in the practice community on when and to send your patient to a psychologist – in what case, what complaints and symptoms – how to explore in order to decide if a psychologist is needed; and how to support the patient in visiting a specialist. It is also important to inform the GP about what he/she can ask from a psychologist to do. How can a psychologist help the patient in acute or chronic conditions, for example, or how he/she can do health and prevention work in the practice, what tools and competences he/she has and works with. For the work of a psychologist, material conditions are also required. In order to create an atmosphere of trust and discretion, a consultation room is required, where overhearing is impossible. This room should be suitable for individual and group consultations, it should have equipment to help create a pleasant atmosphere. It is important to ensure undisturbedness and regular ordering times. Since at present the material conditions are only partially or not given at all, it depends on the creativity or rather the generosity of the family doctor on how he/she is able to provide the necessary infrastructure conditions for the psychologist.

In addition, it is essential to ensure that the client can contact the psychologist directly without referral from a GP if he or she feels the need.

7. PRACTICAL EXPERIENCE

The case presented highlights exactly how important the presence of a health psychologist is in primary care and how important it is in the healing process that the specialist can support the client in the tense wait for a specialist examination. Judit had planned seeing a psychologist several times before due to her symptoms, but in fact she did not do anything to get to a specialist. In the current situation, however, the specialist was available locally in the GP practice.

Patients with medically unexplainable physical symptoms initially turn to their GP, overloading primary care, after which they are directed to a number of specialist clinics to obtain various exclusionary diagnoses, which usually do not describe what the reasons of the physical symptoms are, rather exclude the factors that do not cause it. It is important that the psychologist can support the client in the use of the specialist examination, since the symptoms can be formed by prolonged stress effects, life-style conflicts, traumas. Therefore, the treatment of this group of patients is much more effective at the level of primary care with the involvement of a health psychologist than in specialized care, where the client can only be admitted for the purpose of seeking special diagnoses. In addition, the process of healing should not, of course, be carried out without the mapping of the personality, the diagnosis or exclusion of a large number of mental disorders in primary care, which is the scope of competence of the clinical psychologist. In future practice communities, therefore, it is not possible to circumvent the process of establishing a cooperation between clinical psychology care and health psychology.

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INTERNAL MEDICINE – A CASE REPORT IN GASTROENTEROLOGY

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1. INTRODUCTION

Internal medicine is a significant and broad discipline in general somatic healthcare. Within the field, diseases that affect the digestive system are of major concern. These include disorders of the upper (i.e., dysphagia, reflux, gastritis, etc.) and the lower (celiac disease, inflammatory bowel disease [IBD] and irritable bowel syndrome [IBS], etc.) gastrointestinal tracts and pancreatic, liver and biliary diseases (Altorjay, 2014). Among these diseases, inflammatory bowel diseases should be highlighted as exercising significantly adverse impacts on the quality of life.

Inflammatory bowel diseases, that is, ulcerative colitis (UC) and Crohn's disease (CD) are multifactorial, immune-mediated inflammatory disorders affecting mainly intestinal tissues. Causal therapy for their treatment is currently unknown; however, symptoms can be effectively supressed with available therapies such as aminosalicylates, corticosteroids, immunosuppressants, and biomedical products (Miheller et al., 2009; Nagy, 2010). Recent studies have drawn attention to the importance of the brain-gut axis in the pathogenesis of IBD (Bonaz & Bernstein, 2013).

Internal medicine diseases are often associated with various mental disorders, such as comorbid psychological distress (Rosselli et al., 2015). Childhood traumas and high levels of stress induce susceptibility not only to certain functional gastrointestinal diseases but also to inflammatory bowel diseases (Van Oudenhove et al., 2016). In the case of mood or anxiety disorders, the association can be attributed to the experienced burden that physical symptoms trigger and the consequential impairment of patients' psychosocial functioning (Bhamre et al., 2018; Byrne et al., 2017; Katon et al., 2007). A higher prevalence rate of intense psychological distress, anxiety, depressive symptoms/depression and other psychiatric disorders have been found in patients with inflammatory bowel diseases. According to the meta-analysis of Zhang and colleagues (2018), patients with inflammatory bowel disease also face an increased risk of suicide (Bernstein et al., 2019; Navabi et al., 2018; Neuendorf et al., 2016; Stapersma et al., 2018; Zhang et al., 2018). Another recurring theme of recent research is the significantly decreased quality of life in people with gastrointestinal diseases (Knowles et al., 2018; Maity & Thomas, 2007; Martínez-Martinez et al., 2019). In IBD, stress, depression and anxiety manifest as a vicious circle – they can be either the cause or the effect of the disease – in the sense that there is a bidirectional process between these mental and intestinal diseases: distress, depression and anxiety can trigger the physical symptoms or, conversely, the disease is stressful enough to induce mental problems. Although etiology is not completely clear yet, anxiety and depression are known to have adverse impacts on the course and exacerbations of the illness as well as on the frequency of necessary medical treatments and services (Bannaga & Selinger, 2015; Graff et al., 2009; Keefer & Kane, 2017; Navabi et al., 2018). Patients might exhibit a range of psychosocial symptoms as well, for instance, they might experience emotional imbalance and lowered self-esteem, which might cause their sense of personal control to deteriorate, along with their autonomy and body image. The investigation of IBD patients' illness perception may provide important information as illness perception influences health behaviour and the choice of adaptive or maladaptive coping strategies (DeJong et al., 2012). Findings of a study conducted by Rochelle and Fidler (2013) indicate that patient perception of their illness as being long-term and chronic brings about an elevated level of depression and more intense negative emotions.

Long and colleagues (2014) emphasize that psychological factors might affect patients' responses to treatment and even influence directly the clinical outcome of the disease. With a view to all the psychological risk factors and the psychological consequences of these chronic diseases, the complex biopsychosocial approach highlights the importance of taking advantage of the benefits of psychology in healthcare. Therefore, the main goals of health psychology in tertiary prevention needs to target the detection of possible psychological risk factors, the treatment of the psychological comorbidities of a chronic disease, the prevention of psychological decompensation and the support for patients' effective coping and self-management strategies (Dudley-Brown, 2002). This multidisciplinary approach points out the importance of psychological care in collaborative healthcare, as it is beneficial both in terms of improving the quality of healthcare and nurturing the collaboration among the different disciplines.

2. CASE STUDY

Our aim is to present the development of comorbid mental dysfunctioning in gastrointestinal diseases and the possible advantages of available health psychology interventions. The patient provided his informed written consent to the publication of his case.

Inflammatory bowel diseases display a range of similarities concerning their symptoms, course and treatment options; however, there are several differences between them as well. Crohn's disease may affect any portion of the gastrointestinal tract, from the oral cavity to the rectum; however, its occurrence is most typical in the small intestine and the colon. Some parts of the digestive system are affected, whereas other parts may be not, and the disease expands to all layers of the mucosa. Its most common symptoms are abdominal pain, weight loss, diarrhoea and fever. Strictures, adhesions and fistulas may occur as complications. Extra intestinal manifestations often affect the liver, the eyes and the skin. In order to manage symptoms, treatment often involves surgical interventions as well. Patients need lifelong medical surveillance in order to avoid or treat relapses (Kovács & Lakatos, 2018).

2.1. THE INITIAL APPOINTMENT

The patient (Tamás) asked for psychological support himself in order to ease his disease-related psychological strains. We scheduled an outpatient appointment. Tamás arrived on time.

He is a tall, thin young man, though looks a bit older than his age. His communication was dynamic, explicit, organised; he had been living with the disease for several years, so he talked about his complaints in a natural manner. His eyes seemed clear and honest; his physical appearance gave the impression of being friendly, open and intelligent. He is in his early forties.

He has been struggling with the disease for twenty years. As he put it during our first session, he 'felt chaotic, disorganised and nervous'. After the health-related challenges of the first few years, he had a remission period; however, in the last few years, his disease has become active again and he has experienced further health problems. He felt his every-day struggles with the disease demanding to such an extent that it affected and restricted all areas of his life. His fears and anxieties about his health and the future were also increasing. In addition to IBD, intercurrent diseases such as rheumatic complaints, tumour processes, lupus (systemic lupus erythematosus, SLE) and reflux developed.

His reasons for seeking therapy included fatigue, deterioration of performance and his doubts about the future and his health. The topics we identified to be targeted in sessions were his decreased pain tolerance, sleep difficulties, digestive problems and his role as a patient; he felt his body had become 'worn out', it did not serve him properly anymore. His attitude towards his own body had changed and he felt it a complete failure.

2.2. FAMILY MEDICAL HISTORY

His family of origin consists of his mother, father and elder brother. As for his birth circumstances, he was the second child of a rural family with a stable and safe background. He arrived one week before the expected date. His parents did not plan a second child and had already a boy as their firstborn thus they would have preferred having a girl, yet they welcomed Tamás's arrival. As an infant, he was in hospital a few times, he does not know exactly why. He cherished his years in kindergarten, which he attended for three years. He loved studying from day one of his school years; he used to read his brother's books. During adolescence, he began spending more time with his peers, which caused a slight drop in his school performance. Until graduation, he had never been ill except for some minor colds. He could not recall having any accidents.

He described his mother as being overprotective and overshielding. He had a much more relaxed, balanced relationship with his father and a somewhat distant but good relationship with his brother. He had his first romantic relationship around the end of his secondary school years. After graduation, he went to college and earned a degree in agricultural engineering. His disease first manifested in the first year of college, he was hospitalised and had to undergo a life-saving surgery. He had to defer a semester but passed all his exams in the next one. Unfortunately, his first romantic relationship did not bear the burden of his disease so they split up. Afterwards, he had two or three shorter relationships but none could endure the difficulties his disease posed.

After graduation, he had a hard time finding a job as his disease required constant medical treatment. He was in his mid-twenties when he was finally offered a position. His love and commitment to his profession developed during the years he spent there. He had supportive, motivating mentors. His physical condition improved and he achieved professional success; both improved his self-confidence. His work became an integrated part of his identity, a source of his self-confidence and self-esteem. That job was a turning point in his life, he left his parents' house and for the first time he felt he could manage his life alone. It was an important period in his life, full of meaningful tasks that contributed to his development and advancement. He felt content in his different roles such as his male gender role and his social role as an active and successful professional and wage earner. Despite his illness, he was ambitious to improve and become fully independent. He met his current partner and they got married in this period. Answering my question, he denoted his wife and some of his friends as his most important social support.

2.3. PATIENT'S MEDICAL HISTORY

During the exploration of the history of his disease, I could notice his sense of bitterness, but also a sense of humour and the ability to laugh at himself. Due to frequent flare-up episodes since the onset of the Crohn disease he had undergone several operations and there had also been several changes in his treatment plan.

As mentioned earlier, he had rarely been sick in childhood, 'being ill' was an unfamiliar state/role to him until his first year at college. There were important phases in his illness:

1. His disease developed at the age of 19 when he needed a life-saving surgery and he was hospitalised for two months. He had to cope with emotionally demanding events such as the abrupt onset of the disease, his weight loss and the operation. The challenges of the postoperative period have also made him face a number of new and strenuous challenges.

2. Successively he had a longer remission period, though he needed frequent medical checkups. During this period he could work actively and, as a result, he had success and recognition at work; he could experience being productive despite his disease.

3. However, some years ago, another relapse period started abruptly. Due to the development of a subileus (partial bowel obstruction), he was admitted to hospital again. Again, he had a colostomy, and rheumatic involvement and autoimmune processes (SLE) were also suspected. After the surgery, he received a temporary ostomy pouch system; the stoma was reversed after a few months. Later, a tumour was found in a sample taken from the intestinal tract, but the therapy he received ruled out oncology treatment. Examinations did not detect remaining tumour tissues inside. He was suffering from severe pain, which necessitated neurological and psychiatric consultations in order to alleviate the pain and related fears. He received biologic therapy for Crohn's disease, supplemented with steroid therapy from time to time to suppress inflammatory processes. Afterwards his disease remained constantly active; he more or less managed to keep it in under control. He had also been operated on his heart five years ago, due to a disorder that might have developed linked to his lupus. By that time, he had reached the limits of his physical performance. He tried to work again for a short period, part-time, but later, following the instructions of his physicians, he stopped working. It was a serious trauma in his life. He had never been negligent concerning his illness and always adhered to treatment, hence he felt betrayed and had negative emotions, such as frustration, while deprivation and disappointment also occured.

Even at the time of our counseling, he was receiving concurrent medical treatments focusing mainly on gastroenterological care, but due to systemic symptoms, he also had to go for regular rheumatological and neurological checkups.

With regard to his physical condition, the experience of low body weight, weight loss, the frequent and prolonged pain, side effects of the drugs and mood swings upset him the most. The decline of his health due to the constant progression of the disease challenged his mental well-being as well. Adaption to the new structure and to the new daily routine also evoked stress in him. In the current stage of the disease, Tamás is receiving immunosuppressive therapy and anti-inflammatory drugs (steroids), as well as painkillers and anxiolytics, depending on his complaints and condition.

2.4. THE COURSE OF HEALTH PSYCHOLOGY SESSIONS

Tamás took part in 12 therapeutic sessions altogether, including personal and online meetings. During the first appointment, we had an initial disclosure stage to get to know each other and he was given detailed information about the framework of the therapy; afterwards, he detailed his medical history and his reasons for seeking therapy. Then we identified his needs, the aims of the sessions and set the frames. His main goals were to (1) improve his sleep quality and his dietary habits; (2) get a deeper understanding of his health-related fears; (3) to develop a more effective adaptation to his changed lifestyle (the loss of his ability to work); and (4) ease his social isolation. He also mentioned his further, long-term plans and expectations: development as well as maintenance of his vitality, physical strength and mental health.

In order to improve his sleep quality and build better sleep hygiene, we explored his sleep habits and he was provided psychoeducation. To monitor his sleep quality, we agreed on his keeping a sleep diary that would enable us track and correct his maladaptive sleep practices, the amount of time he spent awake at night, his personal impressions and his perceived pain during the night. Furthermore, he was taught a specific relaxation technique (progressive muscle relaxation) in order to support his mental balance, lessen his perception of pain and further improve his quality of sleep. Tamás was open to both keeping a sleep diary and trying out relaxation exercises, and was generally interested in learning new self-management skills. He bought a notebook in which he recorded his experiences relating to practising at home and sleeping. He was highly motivated: he sent in all his recorded previous-week data before every session so we could discuss his emergent questions and experiences on a regular basis. Self-monitoring and the constant feedback received improved his sense of control; later, for the same reason, he started keeping a thought diary as well. These tools helped him improve his knowledge about his own self as he attained a deeper understanding of the connections between his emotions, physical perceptions and behaviour. We started to use each of the therapeutic techniques mentioned gradually, introducing a new technique when the active process of the therapy required it. Each step was followed by psychoeducation and monitoring.

After a few weeks, Tamás deployed his newly developed skills with confidence, incorporated the progressive muscle relaxation technique in his daily routine and, as for his sleep quality, he managed to observe some interrelations between weather changes, his sleep quality and painkiller needs.

When he was at home, he paid conscious attention to his re-structured daily routine. He focused on the even distribution of tasks around getting up, daily tasks and bedtime; this proved to have a stress-reducing effect despite the social isolation due to the COVID-19 pandemic. Although, in previous years, his perfectionism had bred not only benefits, but also some negative payoffs, such as excessive, exhausting performance and thus exploitation of his energy supplies, in his current situation, his well-organised and perfectionist character helped him a lot to accomplish his daily tasks.

Due to the thorough changes in his social and family roles, he often felt vulnerable and disappointed, and on those days when he had severe pain, he often became moody, experiencing fatigue and depression. At the onset of the therapy, we assessed his mental condition via self-administered questionnaires. We used the Patients' Health Questionnaire (PHQ-9) (Kroenke et al., 2001, 2002) to measure depressive symptoms, and the Spielberger State Trait Anxiety Inventory (STAI) to assess anxiety (Spielberger et al., 1970; Sipos & Sipos, 1983). The degree to which his illness restricted his life was assessed by the tools of the Illness Intrusiveness Rating Scale (Devins et al., 1993; Novak et al., 2005) and The Short Inflammatory Bowel Disease Questionnaire (SIBDQ) (Irvine et al., 1996; Újszászy & Horváth, 2011). The values he scored both for anxiety and for depression fell within the range of moderate degree; this was in line with my personal expectation and the client's self-reflection. As for the intrusiveness of the illness, it significantly influenced his life and showed a drop in the level of his quality of life.

Before the onset of therapy, following instructions by his psychiatrist, he had started taking anxiolytics and they reviewed its daily dose on regular check-ups, but Tamás self-regulated their dose within the prescribed three tablets per day. In most cases, he used them to aid falling asleep or when he felt unable to cope with his overwhelming distress during the day.

The Illness Intrusiveness test also detected that the current COVID-19 epidemic contributed to Tamás's elevated level of stress. Tamás highlighted social isolation as one of the most difficult burdens he had to cope with.

All in all, his quality of life had deteriorated significantly due to his illness and was thus much lower than the average; it affected all domains of his life and impeded even his everyday functioning.

Tamás's life has been dramatically changed in terms of dietary habits, physical activities, social tasks, work, intimacy and financial situation. His self-image of being an active person and a wage-earner, an ambitious man, dedicated to his profession, had faded away after he had withdrawn from work on his doctors' instructions. One of the most important components that had built up his self-esteem used to be his success at work, which had helped him ignore his negative body image and the embarrassing symptoms, such as dramatic weight loss or the temporary ostomy pouch attached.

His coping strategies during his productive periods could be termed problem-focused, characterised by goal-oriented stamina and strength. However, during the physically difficult phases of the disease he often failed to utilise his adaptive coping strategies. Instead, despair, fear of the future, anger and helplessness started to overwhelm him in these periods. Due to malabsorption, he lost his appetite, developed a negative body image, and no nutritional formulas proved to be efficient. (Patients in general have difficulties in tolerating liquid formulas despite their numerous known advantages.) As it is typical for patients with IBD, Tamás also reported a lack of appetite that can be attributed to the related pain, malabsorption, nausea, abdominal cramps, frequent bowel movements and outputs as well as the unsatisfactory culinary experience.

Via therapeutic tools, such as the review of his eating habits, exploration of his eating-related thoughts and feelings, psychoeducation on possible alternatives and scheduling meals into his daily routine, he managed to improve his appetite, gain weight, and, later, he could even highlight some rare moments when he was able to find joy in eating. All these techniques helped him stick to his goal and sustain his motivation.

He recounted that he had received ambivalent reactions from his social environment when he was talking about his health problems; some people either felt sorry and pity for him or, sometimes, they became impatient. He felt being stigmatised and thus withdrew from social interactions due to the negative feedback he received. He felt being defenceless and often overreacted to opinions he got. However, he himself nurtured ambiguous feelings on the issue: on the one hand, he was offended when people were not able to understand him and his problems; on the other hand, he did not want others to feel pity for him. Sometimes he had outbursts of anger and bitterness when he was with the people who supported him most, thus he hurt the ones whom he really did not want to. He often felt anger and frustration, feelings he wanted to get rid of, but he certainly did not want to put its burden on his family. In terms of interpersonal relationships, his prevailing emotions were that of shame, doubt, insecurity, tension and fear. As for his attitude towards his own behaviour, he demanded himself to stay strong, disciplined and determined – he refused to let himself dwell on self-pity. He often criticised and blamed himself.

He was highly motivated in taking part in the counseling process and was open to articulate his feelings during the sessions. He felt it to be very important that he could express his stress-evoking thoughts openly in a situation in which he did not have to restrain himself trying to be tactful and respectful of others. (By that point in therapy, the supportive relationship between the counselor and the client and the safe place had already reached its aim and could act as a 'container', making ventilation possible for the client. In the unsuspecting, non-judgemental, holding environment, the client had a sense of security and could express his feelings freely, without receiving criticism.)

The representation and the perception of his illness focused on it as a 'loss' – it has stolen/taken a lot from me', referring to his health, his further education, career advancement and developing important relationships.

Despite all his difficulties, his coping repertoire still encompassed adaptive strategies. He was sticking to his daily routine, he and his health care providers cooperated on taking illness-related decisions, he strictly adhered to treatment regimen and took responsibility to maintain and manage his health condition. He went for regular check-ups and evaluated his relationship with his gastroenterologist as appropriate. He planned all his health-related tasks carefully and meticulously, assessed his possibilities and adjusted his to-do list to his scope. This helped his adaptation and created some sense of autonomy.

However, regarding his emotion, relationship and conflict management, he displayed some *less adaptive coping strategies,* such as *avoidance and passive coping.* These increased the level of his subjective perception of stress and due to the overlap of the various stressors, he often released tension more intensely than he intended to. This further intensified his tension, which in turn led to a decrease in his self-esteem, a negative attitude towards himself and adversely affected his interpersonal relationships as well, resulting in numerous conflicts.

We are of the opinion that the use of these techniques, i.e., supporting the overt articulation of his emotions, helping the development of his adaptive and assertive communication skills and the use of recording his thoughts may improve his stress-management, efficacy of coping and quality of social interactions. Concerning the clinical course of his disease, development of these skills may also yield a better relationship with his health care providers and strengthen his treatment adherence. Better communication with his health care providers may bring about a better coordination of the related areas, as previously there had been information-flow problems hindering his treatment. This, in turn, may also help his recovery. The newly acquired skills to express his emotions more explicitly and the thought diary technique that helps him evaluate his thoughts, feelings and behaviours also added to the maintenance and improvement of his health-related active attitude and adequate behaviour. By the end of the counseling process, he had achieved improvement in all these domains of his self-efficacy.

Regarding his resources, he identifies his wife as the most important protective factor, who has been standing by his side for more than ten years, giving him a sense of stability, consistency and security. He considers his wife as his faithful partner and support, and the relationship between them as a double alliance and life-long commitment. As for his other social resources, he has two close friends who have also supported him throughout these difficult years and he knows he can rely on them under any circumstances. When he experienced the most difficult troubles and could talk about nothing but his illness, they took the time and listened to him with empathy.

In addition, his house and its garden, the quiet, green, friendly area also had a calming and inspiring effect on Tamás. Furthermore, as he spent more time at home alone, he developed a close relationship with his dog. He said that being alone used to have a negative impact on him and launch a downward spiral of his negative thoughts, but whenever he went out to the garden and his dog was jumping around him, everything seemed easier and less frightening.

During our therapy, his poor health prevented him from doing physical activities; however, later, his appetite increased and he managed to gain some weight that helped him take a short walk, renovate or do some smaller tasks around his house. These improved his physical well-being and moderated his mood swings as well.

However, among all the topics he brought up, his illness was the most significant: for many years, he had been thinking of it as a long battle, but now, after our sessions, he can see it as an opportunity for development. His recovery from the traumatic events he has experienced helps him sustain his inner strength, stamina, endurance, even if sometimes he feels a lack of energy. Staying at home cut off external stimuli, turned his attention inward and forced him to deal with himself. He was often unable to manage his severe pain, which heightened his sense of lack of autonomy. His mood swings also elicited fatigue, increased his distress and exerted a negative effect on his physical well-being, social interactions and nighttime rest. Moreover, feelings of being vulnerable, lack of control and ambivalence determined his attitude towards his career, tasks and illness perception. His own needs and expectations further intensified it. He felt that his negative perception of his illness sometimes overwhelmed him and he also failed to meet social expectations of male gender roles, which damaged his self-esteem: he was not the breadwinner in the family any longer, he was the one to stay at home and do household chores (to the extent he was capable of). During our therapy, it was a long and difficult process to integrate all these topics, but reframing and adjusting his goals to his new roles, the support of his wife and his established financial stability made it easier. Yet, his pessimism about the future and his health arose and engulfed him at times, mostly in times of decline either in his health condition or in the efficacy of his coping. We tried to identify the things in his current situation that would make him as proud as he used to be and find elements of his life that were worth living for. Using the technique of mental imagery, I asked him to visualise nature images and associate previous and current experiences and prevailing emotions with them. These elicited complex and condensed emotions and moods that proved important. Talking about his emotions was difficult for Tamás, but gradually we were able to explore them as he did his best to improve in this area as well.

2.5. REFLECTIONS OF THE CLIENT ENDING THE THERAPY

The thought records tool proved efficient in broadening the client's knowledge on his own negative automatic thoughts and finding new, more adaptive alternatives. Through embedding his medical history in his life story and identifying his losses (work ability, child, career, his negative attitude towards his body), an emotional processing started to develop that enabled Tamás to loosen his strict, critical tone of self-evaluation and accept his current self. His strict agenda served as a mood-regulator that reduced depressive symptoms and helped him find meaning in his everyday activities. Resource activation, defining his short-term goals and reframing his current situation also supported a positive self-evaluation and self-esteem.

In the endphase of our health psychology counseling sessions, Tamás gave the feedback to us that he had experienced positive changes in various domains of his life. He was glad that his own emotions and expectations about his current situation had been brought to awareness. He felt he had learnt to express himself more explicitly and voice his feelings and requests to others more easily. Our therapy enabled him to identify the things he considered most important in his life and health condition; he felt he managed to reframe his disease-related experiences. The muscle relaxation technique, the sleep diary and the thought records allowed him to create a more relaxed and balanced daily routine that suited him better. His new skills helped him mitigate his tension and improve his perceived autonomy and efficacy. Finally, he stressed how important it was to have less inner monologues during the time when he was being alone. Throughout the entire counseling process, Tamás was highly ambitious to grow, thus we had a productive counseling process. He could sustain his resilience despite the losses of his certain roles and the negative changes in his functionality. In such a difficult situation, he managed to develop his coping strategies and find his personal life goals.

In accordance with the biopsychosocial approach and the multidisciplinary healthcare, psychological service is available to him as part of his gastroenterological care, as several determining factors (i.e., alterations in his medical treatment, decline in health, loss of resources or other factors) may change in his life that can affect his mental and somatic condition as well as his coping, adherence and motivation. Therefore, we agreed to hold regular follow-up sessions in order to maintain the possibility to continue the process if necessary. We had our first follow-up session after one month, and then we scheduled a three-month basis for follow-ups; however, we agreed that our sessions were to accommodate the client's needs, that is, we should consider having more frequent sessions in case difficulties emerged. At the second follow-up session, Tamás reported having gained weight, keeping a balanced mood and the reduced use of anxiolytics; therefore, we maintained our agreement with regard to the three-month basis of our sessions. Follow-up sessions were also held online.

3. DISCUSSION

Inflammatory bowel diseases are immune-mediated processes which, once the diagnosis is established, significantly determine the patients' physical, mental and social conditions and therefore influence their quality of life (Knowles et al., 2018; Maity & Thomas, 2007; Martínez-Martinez et al., 2019). Our case study demonstrates that the progression of the disease, its active periods, the difficulties in treatment and the decline in everyday performance affected Tamás's quality of life.

The applied questionnaires measuring our client's current mental state showed elevated values both in terms of mood disorders and in terms of anxiety; this outcome underpinned my personal impression and the client's self-reflection. Our study is in line with recent international research demonstrating that the level of anxiety, distress and depression is elevated in people with IBD (Bernstein et al., 2019; Navabi et al., 2018; Neuendorf et al., 2016; Stapersma et al., 2018; Zhang et al., 2018). According to research, mental problems occur both as the cause and as the effect of the disease and they affect disease course and exacerbations; our study supports this idea as Tamás's deteriorating somatic symptoms were in clear association with the changes in his mental condition (Graff et al., 2009; Keefer & Kane, 2017; Navabi et al., 2018). We could also observe a two-way connection between inflammatory processes and depressive symptoms. (Gracie et al., 2018; Keefer & Kane, 2017). An active and severe disease, the negative changes in physical appearance (significant weight loss, stoma, extra-intestinal symptoms), previous surgeries and hospital admissions may predispose patients with IBD to a lower quality of life and a heightened level of anxiety and depression (Ananthakrishnan et al., 2013; Iglesias-Rey et al., 2014; Knowles et al., 2018; Lewis et al., 2019; Navabi et al., 2018; Nowakowski et al., 2016). In Tamás's relapse period, all these factors manifested concurrently. His hospital stays, surgeries, malabsorption and the related weight loss and pain all had an adverse impact on his mental well-being as well. Reactions of his social environment further intensified his difficulties and the loss of his work ability further added to his negative emotions. Findings of research show that CD-related stressors trigger worse outcomes of depression, anxiety and quality of life. (Knowles et al., 2018; Navabi et al., 2018).

Our patient's perception of his illness as a 'loss', accompanied by perceived loss of autonomy, incapability and disappointment determined his illness representation. In his coping, we observed adaptive (cooperation, adherence, high-level of self-management) and maladaptive (rumination, avoidance) strategies. During the counseling process, his coping has been widened by such components as the thought records, muscle relaxation, assertivity. McCombie and colleagues (2013) investigated coping strategies in patients with IBD and found that patients with IBD used more emotion-based coping strategies compared to persons in the control group, which has adverse psychological effects. In the active periods of a disease, patients tend to use maladaptive strategies; this finding is also supported by our client's case. However, in his case, increase in his perceived control facilitated the use of adaptive coping strategies and thus enhanced his self-efficacy.

We can conclude that in patients with chronic diseases, especially in patients with inflammatory bowel syndrome, a range of psychological aspects accompany somatic challenges. Physical changes, social isolation, pain, worries about the treatment and complications, development of new diseases may all have significant negative effects on patients' subjective quality of life, mood swings, the progression of the disease and the efficacy of coping. In these cases, tertiary prevention may promote patients' motivation to increase their self-efficacy, reframe, and make the most out of the adverse changes in a way that helps their recovery. Even if they are aware of the fact that complete recovery is impossible.

Mood swings in IBD are considered typical; however, anxiety relief–via stress management techniques–may help to reduce the patients' vulnerability, sense of autonomy loss and debilitating frustration. In our counseling process, Tamás's frankness with himself, his honest and trustful attitude towards me founded a therapeutic foundation to base his personal goals on. The systematic review of his experiences with the disease provided a new perspective to his long-standing, emotionally highly demanding battle with the disease. Exploration and conscious use of his resources also increased his personal efficacy. His commitment and work during therapy was remarkable, as patients in similar situations tend to be so overwhelmed that they are unable to activate their energy to become motivated. Therefore, in our therapy, one of the most important targets of the health psychologist's work was to facilitate the improvement of the client's own skills. In health psychology counselling, it is also inevitable to strengthen the patients' treatment adherence and help them build a strong trust in their own abilities. This way, health psychologists can support patients' self-management and self-competence with regard to the course and the emotional processing of the disease.

Lessons learnt from this case

In cases of chronic diseases, care provided by the health psychologist, if started early enough in tertiary prevention, may enable patients to cope effectively with their disease-related burdens. Employed health psychologists can help patients' activate their available external and internal resources, thus they can motivate them to establish personal goals; patients therefore may feel more efficient in their health management.

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HEALTH PSYCHOLOGICAL ASPECTS IN THE TREATMENT OF CARDIOVASCULAR PATIENTS

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1. INTRODUCTION

Cardiovascular diseases (CVD) are the leading cause of death worldwide. In Europe, CVD is responsible for 43% of total mortality (Timmis et al., 2018), and in 2019 cardiovascular disease accounted for nearly half of all deaths in Hungary, according to the Global Burden of Disease Study.

The most common diseases of the cardiovascular system include: *1. ischemic heart disease,* which results from a pathological process of narrowing and/or occlusion of the coronary arteries that supply oxygen and nutrients to the heart (Aaronson et al., 2000); *2. chronic heart failure,* when the heart is unable to provide the filling pressure of cardiac output required for tissue blood flow due to the reduced ability of the heart muscle to contract, or the natural aging process of the left ventricle, or other causes; and *3. arrhythmias* (abnormalities of heart rhythm or heart rate), by which we mean problems with the formation or drainage of a stimulus (Aaronson et al., 2000).

Risk factors for cardiovascular diseases are classified into non-controllable and controllable categories. Risk factors that cannot be controlled include age, gender, and familial incidence of heart disease (genetic factors). Controllable risk factors include dyslipidaemia (abnormal levels of one or more lipoproteins), hypertension (blood pressure above 140/90 mmHg), diabetes, and obesity, which may be alleviated or eliminated by lifestyle changes or medication. Controllable and lifestyle-related factors include unhealthy eating, physical inactivity, smoking, and excessive alcohol consumption (Aaronson et al., 2000).

*Psychosocial risk factor*s can be classified into 3 major categories (Piepoli et al., 2016).

1.1. ACUTE STRESSORS (FOR EXAMPLE JOB LOSS, DEATH IN THE FAMILY) AND CHRONIC STRESSORS (E.G. WORK-RELATED STRESS, MARITAL STRESS, LOW SOCIAL SUPPORT, LOW SOCIO-ECONOMIC SITUATION)

Acute mental stress through the autonomic nervous system can result in acute cardiac symptoms and events or acute cardiac death. Studies have linked these cardiac events predominantly to traumatic experiences suffered acutely in the previous 24 hours (Kumar & Goel, 2008). *Chronic work-related stress* causes a two- to three-fold increase in the probability of cardiac event. Determining factors include overwork, low sense of control, lack of recognition, shift work, monotonous work activity, and the threat of unemployment (Kivimaki et al., 2002). While work-related stress is of paramount importance among men, marital stress (negative, dismissive, or hostile behaviour of the spouse) is the leading factor among women (Balog & Mészáros, 2005). In relation with *social support,* namely the absence of it, the unavailability of support resources and complete social isolation pose an increased risk for heart patients (Everson-Rose & Lewis, 2005), while low socioeconomic status accompanied by an unhealthy lifestyle is generally associated with an increased cardiac risk factor (Albert et al., 2006).

1.2. NEGATIVE EMOTIONAL OR MOOD DISORDERS OR OTHER PSYCHOPATHOLOGICAL SYMPTOMS: DEPRESSION, ANXIETY, VITAL EXHAUSTION, SLEEP DISTURBANCE

Major depression and depressive symptoms below the psychiatric diagnostic threshold, as well as prolonged above-average *anxiety,* could be independent risk factors for CVD and probably a consequence of heart disease (Everson-Rose & Lewis, 2005; Roest et al., 2010).

Vital exhaustion (fatigue/weariness, increased irritability, and feelings of discouragement/hopelessness) is a long-term predictor of myocardial infarction and fatal coronary heart disease (Appels, 1990), and the presence of *insomnia* in a cardiologically healthy population increases the likelihood of developing and / or dying from heart disease by 45% (Sofi et al., 2014).

Furthermore, *short sleep time* (<5–6 hours) and too *long sleep time* (> 9–10 hours) and *a number of other sleep disorders*, e.g. sleep apnea syndrome may also be associated with the development of cardiovascular disease (Kronholm et al., 2011; Mezick et al., 2011; Sofi et al., 2014).

1.3. MALADADAPTIVE PERSONALITY TRAITS: HOSTILITY AND/OR TENDENCY TO ANGER AND/OR AGGRESSIVE BEHAVIOUR; D-TYPE PERSONALITY TRAITS (PIEPOLI ET AL., 2016).

Hostility and chronic anger (Williams, 1987) have been shown to have moderate significance associated with the development and poorer prognosis of CVD and coronary artery disease, especially the latter (Chida & Steptoe, 2009).

The traits of the D-type personality construct (negative affectivity and social inhibition) together show a strong association with morbidity and mortality connected with coronary heart disease. In terms of maladaptive personality traits, increased levels of physiological hyperreactivity and increased activity of pro-inflammatory cytokines are suggested (Pedersen & Denollet, 2003; Williams et al., 2000).

It is important to emphasize that the risk factors presented above add up and in the short, medium, and long term can have an effect and not in isolation, which may eventually lead to coronary artery disease as a kind of ultimate common pathway. It should also be accentuated – and necessarily taken into account as a basic principle when designing prevention and rehabilitation programs – that in most cases the effect of these factors is not merely added together, but exponential (Tiringer, 2017).

The goal of cardiological rehabilitation programs is to reduce the physical and psychiatric symptoms of heart disease, stabilize atherosclerotic processes, and improve the functional and psychosocial status of heart patients which could improve their quality of life and decrease the likelihood and severity of relapses or cardiac death.

Cardiological rehabilitation is a multidisciplinary program in the form of an outpatient or institutional setting, which is supervised by a cardiological rehabilitation specialist and involves a number of health professionals working in different fields, e.g. dietitians, physiotherapists, psychologists, social workers (Veress et al., 2003).

In the process of cardiac rehabilitation, psychological activity is of paramount importance, including assessing mental status, exploring psychosocial risk factors and initiating ways to change them (for example support to quit smoking), and stimulating coping resources such as mobilizing social supporters and learning stress management techniques (Linden et al., 2007).

During the psychological activity, depending on the degree, *health psychological and clinical psychological interventions* can be applied. For health psychological interventions, programs developed on the basis of empirically supported theoretical models are more effective. These interventions include, for example, increasing risk perception and personal efficacy, planning to implement health behaviours and then using self-control techniques during execution, and taking into account the patient's current motivation and their stage of change (Witte & Allen, 2000).

2. THE CASE OF ZOLTÁN – A TYPICAL CASE STUDY ILLUSTRATING THE RELATIONSHIP BETWEEN CORONARY ARTERY DISEASE AND PSYCHOLOGICAL FACTORS

To illustrate the theoretical and practical aspects of our chapter so far, we present a fictional case compiled from our general clinical experience. In this case, we would also like to point out that although scientific evidence convincingly demonstrates the importance of psychosocial factors in cardiovascular disease, clinical practice still has not reflected much on it.

Zoltán is 45 years old, living alone, working in a large factory as a skilled worker. Four years ago he divorced from his wife, who moved to a neighboring town with their children (then 8 and 12 years old). Conflicts over contact with his children and child visitation issues are still regular. Zoltán rarely sees his children, and he still feels distant from them. His financial situation is also difficult due to the payment of child support. He does not feel well in his partnership over the past two years because his partner (43 years old) is quite busy with problems with her adolescent son. They are usually only able to meet on weekends, which sometimes conflicts with visiting their own children. Zoltán has been smoking for 15 years, and has been smoking 30 cigarettes a day for a long time. He eats mostly in restaurants; he especially likes fast food and eats a lot of bread, while he rarely eats fruit and vegetables. At a height of 179 cm, he weighs 92 kg. He was diagnosed with high blood pressure four years ago (approximately 150/90 mmHg; but he also often measured 180/105 mmHg at a time when the workplace atmosphere was more tense due to competition between employees, an unstable economic situation, and possible layoffs).

He used to play football, which he had to stop at the age of 32 due to an injury. Except for casual exercise with children, he is no longer active in sports. He has no close friends; he maintains some more personal relationships at work. His most important relationship is with his girlfriend, but he is overwhelmed by his own problems.

Basically, it is difficult for Zoltán to talk about topics that affect his emotions. He tried to get over the supposedly depressive period after the divorce and move by burying himself in work. He feels quite alone with his current workplace conflicts. (“No one can help me.”)

One day, when he felt pain and weakness in his chest at work, his boss immediately sent him to the emergency room, but his symptoms eased before the examination. ECG and laboratory examination did not indicate an acute myocardial infarction. The examining doctor recommended further cardiac examination and mapping of coronary heart disease risk factors. Zoltán did not accept this advice until his complaints came back again. He worried about his absence from his job because of the tests and treatment, which would make his boss resent him. He did not want to appear weak in front of his colleagues in the context of fierce competition. He was also worried about what might happen if he had surgery. Instinctively, he dismissed the idea that he might even have serious heart disease. He linked his chest pain, which occurred several times in the following period, to lack of fitness and smoking, but he refused to give the latter up because he was able to manage his tension with it.

Two years after the first chest symptoms, early one morning Zoltán woke up to feeling pain behind his sternum around 4 a.m., which also radiated to his back and upper jaw. He was really scared, and very sweaty. He reassured himself that he might have just got a stomach bug, so he drank a glass of milk, but that didn’t really help either. There was a growing fear inside him. “Is there still a problem with my heart? Is the situation really as serious as it feels now? Should he call an ambulance?” But still, it would only be embarrassing if they didn’t find anything serious in the end, as had happened before in the emergency room. Maybe it will get better on its own and go away. Nothing wrong has ever happened before.

The pain was hard on Zoltán, but he tried to hold on. He walked up and down in the apartment, trying to divert his attention. Then he lit a cigarette, as he used to do in stressful situations, but his pain didn't go away. “I'm only going to see my GP in the morning,” he thought. Since the situation hadn’t improved by 7.30, he did actually go there.

He collapsed in the GP waiting room. The ECG showed an increase in ST-segment, signs of posterior wall infarction, and an intermittent grade 3 AV block. His GP immediately called the ambulance and took him to the Heart Center, where he was immediately catheterized: the large occluded coronary artery was opened and a mesh (“stent”) was inserted. After the successful intervention, Zoltán was placed in the intensive care unit.

After cardiac catheterization and vascular network implantation, Zoltán was relieved and his pain disappeared. His doctor informed him about his extensive heart attack. Although the worst was fortunately prevented, it is likely that his heart’s pumping performance was impaired. In addition, there may be additional moderate stenoses in his coronary arteries that may need to be treated in the future. The doctor emphasized that Zoltán should also take heart medication regularly and make radical changes to his lifestyle: he should stop smoking immediately, eat healthier, exercise regularly, and avoid stressful situations.

Zoltán's doctor is very busy, so he had to continue to rush to the next procedure. During the five-minute conversation, Zoltán could neither come up with his own questions nor tell his difficult feelings about the whole story. Thoughts swirled in his head: what does he have to do now? Which medications should he take? Why does he need them?

Are there any possible side effects? Hopefully he will be able to stop taking the medication soon. And what about eating, playing sports, and “avoiding stress”? He understood that he really had to quit smoking now. The overnight stay in the hospital was a good opportunity not to light a cigarette. And what happened was so frightening for him that he even decided he wasn’t going to smoke anymore. In the following days during time-tight doctoral visits, there was no opportunity to question doctors or express his own insecurities. However, he agreed to go on a hospital rehabilitation treatment in the future. He was told in the last conversation that, after all, he was lucky to have survived a heart attack, but his heart pump function was performing only at 40%, so he would need to take medications for the rest of his life. This news upset him, because he had had no complaints since catheterization.

During the rehabilitation, Zoltán had a short conversation with his doctor, which was difficult to follow here and there, leaving little time for questions, so many things remained unclear for him. What does 40% pump performance mean for his everyday life and work? It sounds pretty low. He couldn't even remember which medicine was meant for what symptom. Moreover, he heard from fellow patients that medications could cause muscle pain, erectile dysfunction, and other unpleasant side effects. Can these symptoms occur to him? How would his girlfriend react if they would have "problems"? And how would he survive in the long run without his smoking rituals? He had tried to quit several times, but never managed to keep it up for more than a few days. When his daughter was born, he decided to stop smoking. A lot of his money was spent on packs of cigarette and it gave him a bad feeling that he was taking it away from his children. But after half a year, as he had more and more arguments with his wife, he fell back and has not tried harder since then. Ever since he became divorced and broken spiritually, he smoked even more.

Rehabilitation treatment was much more organized than he thought. On weekdays, they participated in programs according to a pre-arranged schedule. After a medical visit, the morning was always full of exercise. In the afternoon, they took part in a group session. For example, there was a dietary recommendation every week, and on one occasion they even prepared healthy meals together. Although Zoltán did not have much confidence in the food excempt from meat, the meal cooked by the group was really delicious, although he had a hard time imagining trying out similar recipes on the weekends.

In the group program they focused one week on stress management; another week they spoke about disease treatment and lifestyle changes. The latter groups were led by a psychologist, which caused mixed feelings in Zoltán. He had never been to a psychologist before, and the psychologist or psychiatrist characters he saw in movies were often pretty negative figures for him. However, here in the groups the psychologist mostly talked about coronary heart disease and heart disease, and nothing that would have felt "dangerous" happened. He was relieved to find that the psychologist in the department was friendly and attentive. Should he go in with her? Although the psychologist in the group looked nice, she may not have time for him either.

During the physical training, Zoltán's performance was much weaker than that of older patients, which he was quite ashamed about. "I'm like an old man," he thought. He was thinking a lot about how he would perform in his workplace like this. Luckily, he didn't lose his job; his boss was waiting for him to come back, but probably only because he was always a reliable and well-performing employee. If he was out of work for weeks and unable to perform at his usual level, holding his job may come under risk.

At the disease treatment group, the psychologist said that worries and uncertainties about the future were completely normal, and she reassured patients that their mental state would have a good chance of settling down as they slowly get accustomed to their new life routine with heart disease and deal with everyday problems. She also said that if things were not going so well, their worries wouldn't diminish, and their mood would be permanently depressed; she suggested visiting a psychologist, and she also would offer help to find one. One day the psychologist gave him a short questionnaire on these topics.

During one of the morning visits, smoking as a risk factor was mentioned. Zoltán replied proudly that he had not lit up since his infarction and was seriously determined to put down his cigarettes permanently. The chief physician agreed, although he offered that the psychologist in the department would happily discuss the problem of quitting smoking with him. It was a little bit embarrassing not to be trusted for Zoltán, so he wondered what such a conversation would bring. On the other hand, he was afraid that it would turn out that he had little willpower. However, the psychologist was friendly and she mainly asked questions about his previous experiences with quitting. She praised his performance for not smoking for more than a week. As a homework assignment, she asked him to think through the situations in which his determination could be shaken and what kind of strategies he would apply to avoid it. It was reassuring for Zoltán that this possibility of "tripping up" was being considered. Honestly, he was unsure how solid he would be if he felt the waves crash over his head again. For the next time he also reconsidered that the most difficult situation for him would be when he felt overwhelmed again with his ex-wife's aggressive stubbornness. In addition to smoking, other issues were discussed during their second meeting. The psychologist said the completed questionnaires suggested that he had more severe depressive problems.

When the details of this came up, Zoltán cried, which he hadn't done since his divorce. He was grateful for the psychologist's patience and understanding, which allowed him to tell how miserable he had felt since the heart attack, and that he often felt that his illness had "cut" his life in half. They discussed how his reluctance and fatigue, which had been particularly characteristic since his infarction, could actually be interpreted as symptoms of a moderate depressive disorder. They also talked about the fact that this problem could not be solved in the short time left in his rehabilitation, and that he would have to visit a psychologist near his place of residence with whom he could continue to work to solve his depressive problems. Based on his good experience so far, he would like to take advantage of such an opportunity.

On the third weekend, Zoltán was able to go home from the hospital. He was already looking forward to being with his girlfriend and he was quite disappointed when it turned out she had a program with her son for Saturday night. He had a hard time occupying himself at home alone. He was intensely craving to smoke again. Somehow he didn't expect this situation; he felt confident about his girlfriend's support since his illness. The next day (Sunday) he smoked cigarettes one after the other in the morning. Before lunch, to which his girlfriend had invited him, he did not light up any more because he did not want anyone to be worrying about him. Returning to the final week of rehabilitation treatment on Monday, he didn't tell anyone about his relapse, and he himself was surprised when it seemed quite natural to share his "experience of failure" during his last conversation with the psychologist.

Despite his anticipation, there was nothing like "well, well" and the psychologist said what happened was not uncommon; she was primarily interested in exactly how it happened, and encouraged him that "a slip is not a setback yet". For the rest of the conversation, he was given the opportunity to ask questions about his heart disease. Zoltán felt that he finally had the chance to reflect on his uncertainties and doubts. The psychologist was also very knowledgeable about medical issues, but she mostly steered the conversation toward discussing what and how Zoltán would do differently if he returned to his usual everyday life. In conclusion, he was advised to continue to boldly ask his doctors about his possible uncertainties. In the end, the visit to a psychologist close to his home was discussed again, and he was encouraged that a deeper processing of depressive problems would prevent him from falling back into similar ups and downs in the coming difficult times. This would also improve his chances of solving the problems caused by his heart disease and overcoming the difficulties he faces.

Zoltán pondered a lot about life during the three weeks of his rehabilitation. The group sessions were good, where many of his fellow patients shared their experiences, and everyone seemed to be struggling with their illness in their own way. These topics often continued in a congenial atmosphere in evening conversations. He spent a lot of time with one of his roommates, a “grandfather” 20 years older than him, whom he told almost his entire life story. Zoltán received a lot of encouragement from him. Zoltán realized that he hadn't cared much about his health so far. He had somehow never caught up with this topic before. For example, if an expert talked about something on a TV channel, he quickly got bored and flipped between channels. Now he felt he understood why it was important to deal with this, but he was bothered that what he had learned about heart disease in three weeks was often too complicated for him. He wasn't even sure what applied to him either. Overall, however, his rehabilitation treatment was a useful and good experience.

Zoltán was sent home from rehabilitation and declared fully fit for work with a light to medium workload. Despite this, he was quite worried about whether he would be able to endure the workload. The phrase that there may be more narrowed coronary arteries hit him very hard. What if he gets sick again at work? If it turns out he wouldn’t be reliable? His fears, fortunately, proved unfounded. His reassurance was also due to the fact that he had some meetings with his GP, where in addition to prescribing medication, he was able to talk for a few minutes about the difficulties of lifestyle change. And at the cardiology clinic, he met his therapist, who made a good impression on him: he was attentive, calm, and seemed knowledgeable in his field. The relatively good results of the control laboratory and ECG tests also helped Zoltán's worries to disappear and inspired him to take his medication regularly.

However, his mood was still not very good. He felt stressed to spend evenings alone; on weekdays, and on the other hand, he was afraid of being with his girlfriend because he was unsure how things “would work out”. He was trying to occupy himself and had already changed his lifestyle in a few things. For example, he decided to go to a local team football game regularly. The football field was far away, but he always went on foot so he could have at least one beer with his friends after the match. He tidied up his dusty old bike kept in the cellar and went shopping by bike regularly. Although he felt he was less able than before, the move still felt good for him. He was determined to buy himself a cool new bike.

After a few weeks of procrastination, he called the psychologist who had been recommended to him during rehabilitation.

Two more weeks passed before he first met him. During the treatment, his current depressive problems were first addressed. Zoltán was initially reserved and distant talking to the psychologist. It was unusual for him to talk to a man about his mental difficulties. However, the therapist always listened carefully and, surprisingly, did not give advice to Zoltán, but helped him to think and understand more deeply the important problems of his life.

The therapist listened to Zoltán's life story with interest and compassion: as a child, he lost his mother at the age of 11, from whom he had received lots of love (she died of breast cancer). His father, a very emotional man who overworked himself, suffered a heart attack at the age of 50. He did not give up his lifestyle after that, still working constantly, until his second heart attack proved to be fatal for him a year later.

Dealing with these losses deepened the therapeutic relationship, and in the meantime his mood began to improve. This laid the groundwork for problems that Zoltán would never have discussed with anyone else, such as his doubts about his manhood and how long his relationship would last. Zoltán managed to let himself go into these “difficult” topics as well. A couple consultation also helped him and his girlfriend to talk more openly about their problems. It turned out that he and his partner both approached the other very cautiously, but at the same time it is clear that this relationship, which they are thinking about in the long term, is important for each of them indeed. It also came up as an idea that they would live together soon after his girlfriend's son moved into a high school dormitory.

At the end of the therapy, Zoltán saw his future more hopefully. The heart attack was a shocking experience for him, but since then positive changes had taken place in his life that he had not thought of before.

From a cardiological point of view, it is important that Zoltán trusts his doctors and despite the sometimes difficult circumstances of the care, he feels he receives comprehensive help in treating his heart disease.

He takes his medication regularly, which is reflected in a favorable changes in his lab values and blood pressure. He had managed to remain smoke-free for four months now and realized that regular exercise was good for him, which he could sustain over the long run.

However, despite the good therapeutic results, it is still questionable whether the results achieved so far will be maintained in his everyday life in the long term.

3. CONCLUSION

Lessons learnt from this case

Psychological, social, and behavioral factors also contribute to the development of cardiovascular disease. If these can be identified and altered in time, the risk of the disease can be reduced. If an acute cardiac event occurs nevertheless, there are often psychological and relational factors behind the patient's late appointment with a physician.

Heart disease is a very significant stressor through psychosocial and biological processes, not infrequently leading to further psychiatric disorders that also impair the quality of life and prognosis of the heart patient concerned. A significant proportion of patients experience difficulties in understanding the complex causes and treatment options for heart disease. Lifestyle changes can usually be the result of long-term efforts. Slippages are common in this process, and sometimes more permanent relapses can occur.

Clearly related, uncontroversial, empathetic communication with the patient is important at all stages of treatment. The psychologist working in the rehabilitation team has the important role to recognize on time the comorbid psychiatric disorders and maladaptive behaviors (e.g., non-adherence) and use an adequate treatment for them.

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HASHIMOTO'S THYROIDITIS IN HEALTH PSYCHOLOGICAL APPROACH

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1. INTRODUCTION

Hashimoto's thyroiditis is a relatively common chronic disease that can affect many areas of health. Most often it is diagnosed in adult young women who face challenges arising from the disease for decades. Even though those affected by this experience need clearer information and support at several points in the process of the disease, we cannot provide adequate results and examples neither around research or care. The main objective of this study is to outline, based on case management experiences, the main difficulties faced by those affected and to make recommendations for complex patient care.

1.1. MEDICAL CHARACTERISTICS OF HASHIMOTO'S THYROIDITIS

Hashimoto's thyroiditis is the most common autoimmune thyroid disease. Although geographical differences can be found in prevalence, it is on the rise worldwide and represents an average annual frequency of 0,003-0,015% (Ragusa et al., 2019). In 70-80% of cases, the condition occurs as asymptomatic, so it does not involve hypothyreosis (Ragusa et al., 2019; Ralli et al., 2018, 2020). Hashimoto's thyroiditis is characterized by strong family accumulation, the background of which has been confirmed as recessive genetic inheritance (Thomsen et al., 2020). Common environmental factors are playing a significant role and they are likely to have an impact through epigenetic modifications (Ralli et al., 2018).

From an immunological point of view, the cessation of immune tolerance is the main feature of the disease, as a result of which autoantibodies are produced against thyroid tissues, and greater infiltration of T lymphocytes into the thyroid gland is observed. As a result of the outlined immunological processes, inflammation, fibrosis and atrophy may develop in the tissues of the thyroid gland (Ragusa et al., 2019; Ralli et al., 2020).

The most commonly mentioned risk factors are ionizing radiation, the effects of certain viral infections and antiviral preparations, selenium deficiency, changes in the balance of female sex hormones, iodine surplus, selenium deficiency, vitamin D deficiency, increased stress levels, and an overly hygienic environment (Ragusa et al., 2019).

20–30% of patients have underactive thyroid glands, and the most common symptoms are related to fatigue, depression, putting on weight, somnolence, decreased concentration and muscle spasms; but physical changes in the thyroid gland can also cause symptoms such as deepening or hoarse voice or difficulty in swallowing (Ragusa et al., 2019). Clinical underactive function is treated by replacing the hormone thyroxine and, if indicated by autoimmune inflammation, the thyroid gland is surgically removed.

1.2. PSYCHOLOGICAL KNOWLEDGE ABOUT HASHIMOTO'S DISEASE

The psychological literature on Hashimoto's thyroiditis is rather poor. The most extensive literature is on quality of life and the comorbidity of psychiatric/neurological disorders.

In the case of thyroid diseases, the deterioration of the quality of life is general, and it does not seem to depend specifically on the level of thyroid hormones, but rather on the degree of autoimmune processes (Groenewegen et al., 2021; Ott et al., 2011). Relevant research so far focused mainly on the question of whether different treatments can improve quality of life. In relation to the replacement of the hormone thyroxine, it has been shown to improve quality of life, but the effect depends primarily on whether the hormone replacement reduces comorbid symptoms and disorders (Al Quran et al., 2020). Studies related to surgeries shown that complete thyroid removal may be more effective in improving the quality of life than medication, which may be related to the possibility autoimmune processes being significantly reduced in the absence of the target tissue (Bektas Uysal & Ayhan, 2016). Although surgery often does not seem justified, for example because there is no clinical level of underactive thyroid gland, or because it is well treated with medication, studies show that it has a positive effect on the quality of life and reduces the overall cost of healthcare in such cases (Memeh et al., 2021; Promberger et al., 2014; Zivaljevic et al., 2015).

In the case of Hashimoto's thyroiditis, the widest range of psychological literature can be found clearly on the topic of comorbid disorders. Hashimoto encephalopathy is well documented (Matsunaga et al., 2019), which has the main characteristic that a group of auto-antibodies is also connected to the tissues of the central nervous system, thereby the inflammatory process taking place may cause neuropsychiatric symptoms (disturbed state of consciousness, decline in cognitive function, psychiatric symptoms, ataxia, tremor, chorea, seizures; bipolar disorder (Kupka et al., 2002; Mussig et al., 2005). In addition to the fact that autoantibodies can cause damage to nerve cells, accumulating and depositing immune complexes can also contribute to neuron destruction and dysfunction through inflammation of blood vessels and micro-thrombotic processes. The activation of glial cells and the inflammatory cytokines they produce also enter the circular process, thus strengthening the damage of neurons and the development of symptoms. In addition to the immunological mechanism, hormonal pathways also "support" the process: elevated THS values commonly observed in Hashimoto's disease contribute to mood and cognitive symptoms, and elevated prolactin levels increase autoimmune mechanisms (Churilov et al., 2019; Leyhe & Müssig, 2014).

Among psychiatric disorders, the literature reports an increased frequency of anxiety disorders and mood disorders. Nearly one third of people diagnosed with Hashimoto's disease have anxiety or mood disorders, which is several times the frequency in the average population (Carta et al., 2005, 2004; Kirim et al., 2012). As these disorders are also more common in patients with normal thyroid hormone values, it is assumed that autoimmunity and changes in the HPA axis and circadian rhythm play a major role in vulnerability (Carta et al., 2004; Giynas Ayhan et al., 2014; Kirim et al., 2012). At the same time, reduced levels of thyroid hormones may also play a role in the difficulties of recovering from stress response, which may also increase the incidence of mood disorders. (Hage & Azar, 2012; Haggerty Jr. & Prange Jr., 1995). Thyroid hormones are also associated with neurotransmitter systems, especially noredrenaline and serotonin, so the lack of adequate vocals of thyroid hormones in both the developing and mature brains can make it difficult to maintain a proper mood (Bauer et al., 2008). Although most of the studies focused on the detection of the frequency of anxiety and mood disorders, Hashimoto's thyroiditis also shows a link with general distress levels and, more broadly, with psychological difficulties and the amount of somatic symptoms (Müssig et al., 2012). And the only study referring to coping presented that dysfunctional coping (strong expression or denial of emotions, emotional and behavioral distancing, substance abuse) also predicts psychological disorders (Yıldız et al., 2017).

1.3. THE MAIN CHALLENGES OF HASHIMOTO'S DISEASE, BASED ON PRACTICAL EXPERIENCE

In this paper I present Hashimoto's disease on the basis of working with a number of people involved, in relation to the patients' "experiences", instead of outlining a specific case. This way I hope the areas, issues and challenges that patients face will be better outlined.

One of the most difficult stages of living with this disease, as with most chronic diseases, can be linked to the period of learning about the diagnosis. Since Hashimoto's disease is primarily diagnosed in young adulthood, most individuals experience a particularly traumatic event when, in their 20s and 30s, they are confronted with an autoimmune disease that according to our current knowledge will accompany them throughout their lives, often accompanied by other autoimmune phenomena and consequences beyond the thyroid metabolism. Reactions to diagnosis (or referring lab results) often include the thought of "what if they are wrong"; and in this case the person begins to collect information that seems to prove that this is not the case after all. It is difficult to accept several components in connection with the diagnosis according to our experience; one of them is the fact of autoimmunity. In the public consciousness, autoimmune diseases are associated with rather negative, serious representations, one of the reasons being that among the many autoimmune diseases, those that are most well-known are those with clearly visible, easily perceptible symptoms and are more often severely progressing (e.g. polyarthritis, multiple sclerosis, type 1 diabetes), and those with less spectacular effects on the quality of life (e.g. psoriasis, coeliacy, Sjogren's syndrome). Similarly, it can cause anxieties after receiving the diagnosis if the person is somewhat familiar with autoimmune diseases and knows that they are associated with each other – as this can increase the sense of threat even more. The representation related to autoimmunity also involves the fact that the person feels – and indeed this is happening on a biological level – that his own body, immune system has "let him down", attacks and harms himself, which is always a more serious experience than a disease explained by external causes, since it can revive strong self-blame.

It is also very stressful that we consider the disease to be incurable, as we know it today, and the physicians themselves often say that "there is nothing to do, the process is going its own way", and then, when the hormone-producing tissues die at such a level that we can talk about underactive thyroid glands in clinical terms, hormone replacement follows. Although from a medical point of view, apart from exceptional cases, the process does not require intervention up to a certain point, patients often experience this message as a "betrayal" due to the lack of complete and reassuring information, since it is very difficult to accept at a young age that they have to watch helplessly that their values are getting worse and that an increasing proportion of the thyroid gland's stock is being damaged. This type of message often prevents those affected from starting the necessary lifestyle change in a timely manner also, even at the level of prevention – which, of course, is not primarily intended to stop the autoimmune process, since we do not have adequate data on this possibility, but rather can help to counteract the more complex phenomena associated with the disease.

However, the impact of the information when receiving the diagnosis also depends on how educated the person is: less health-conscious people accept more easily that their main task is to carry out control tests, follow their condition and, if necessary, take HRT. Those who are more informed and are regular users of social media immediately start collecting information, and the different and contradictory opinions and inaccurate data can cause significant confusion in them, and further increase worrying and anxiety. Since there are many thyroid diseases, and not everyone is well aware of their own diagnosis, extremely harmful advice on lifestyle may also be found.

One of the important questions of the post-diagnosis period could be that Hashimoto's disease itself, in addition to affecting the functioning of the thyroid gland, can have other more general changes and consequences for the functioning of the whole organism. Can it affect the level of other hormones, more broadly the metabolic system, the functioning of the nervous system, and thus cognitive and emotional functioning? Experience has shown that most endocrinologists do not address these issues or only tangentially (e.g. they say that "care should be taken because the patient will be inclined to gain weight easily" or that "it may be more difficult to get pregnant"), but rarely gives a satisfactory explanation that would prepare the person to understand where he/she will have a responsibility to manage his/her own health or condition. Although Hashimoto's disease is frequently diagnosed as a result of some other problem (e.g. significant weight gain, presupposed PCOS, fertility difficulty), and the person meets several specialists, he/she has difficulties understanding his/her condition. Or he/she should invest serious individual efforts and research into what is going on in his/her body in a more complex way, and whether he/she can do anything to "counteract" it.

There are also several reports of difficulties with treatment. Although regular lab tests and control tests also require time and effort, the majority of patients routinely do this after a while. The fact of getting medication in general is more challenging to accept: although we do not know the health-damaging effect of the replacement of thyroid hormones, many people are reluctant to take the prescribed medicine, which is probably due to a lack of adequate information. It can also be stressful if the prescribed hormone preparation is not to be taken in the same dose every day; in this case, in the absence of an appropriate strategy, it can be difficult to follow. There can also be "critical" periods when it is necessary to change the amount of hormone; it is important for the person to understand the reason for this and to accept the need for change.

In addition to medication, which is primarily aimed at replacing the missing thyroid hormone, the issue of the treatment of the autoimmune process may also be discussed. Since Hashimoto's thyroiditis most often means a quiet, slow autoimmune process, it is rare to intervene with drugs that target the immune system. If this is necessary due to the stronger autoimmune process, which also causes other symptoms, it is important to prepare properly and to explain the possible side-effects.

The autoimmune process not only leads to a low amount of thyroid hormone, but also, as a result of tissue damage, can also create deviations in the glandular tissue that also require constant monitoring; and if necessary, surgical intervention. Clarifying this and preparing for surgery can be a more stressful time in the patient's life.

The issue of treatment is also stressful from a non-medical point of view, especially for health-conscious people, since they often get to the point where they want to do something for themselves, or their lifestyle based on the information they "gathered". These needs arise primarily in connection with dieting, alternative or complementary treatments and possibly physical activity. Of course, dieting is one of the most sensitive areas, as it involves three aspects. It is well known that iodine intake can affect the functioning of the thyroid gland, so one of the main questions of dieting is how much iodine one should consume. It is also known that in case of disorders characterized by underactive thyroid gland, weight control is difficult due to a slowdown in metabolism, a significant number of people struggle with overweight, obesity, or that they need a lot of energy investment to regulate and maintain their body weight. The third cause that triggers a diet is the autoimmune process itself. As it has become more and more common that certain types of diets (gluten-free, dairy-free, meat-free) are able to reduce autoimmune processes, many people try or follow a special diet toward this goal. The literature does not yet provide enough consistent data on which diets can be really effective, and in the absence of proper guidance from the attending physician, or because of the "circulating" knowledge, it is very likely that the person will devote a great deal of energy and spend significant amounts on inefficient or even harmful diets.

In relation to lifestyle, mainly due to the increased risk of gaining weight, physical activity is still emphasized; however, the experience is that far fewer people are involved in regular exercise than who are trying different diets or alternative methods. Although it is often said as a medical suggestion that a weight increase should be avoided, genuine and meaningful support and help are rarely given to those affected to realize regular physical activity.

Living with the disease also affects other, more or less transparent areas of life, which are often reported by those affected. But these phenomena, difficulties and changes are rarely coming into the focus of the therapy; most often, even patients themselves do not understand how these affect their condition. In the introduction about the literature above we saw that anxiety, elevated stress levels, depressive mood, emotional irritability, and slowing cognitive functions are the most common of the comorbid psychiatric disorders – and if the person does not have sufficient information on how these "symptoms" and characteristics can be related to their physical condition, it can further increase the feeling of helplessness, feeling of insufficiency and anxiety.

It is more obvious when fertility is affected by the underactive thyroid gland; in such cases, it can also be seen that individuals have a greater motivation to try to "control" their Hashimoto's disease. This often means a stronger commitment to a general healthy lifestyle; diet, weight loss, exercise, stress management, or visiting a psychologist. The stakes are high in these situations/periods and people mobilize greater capacity to achieve the goal of childbearing.

As we have discussed, the difficulties of working with patients in health psychology have been outlined, which can serve as a starting point for trying to outline a treatment protocol. That's what we're trying to complete in the last chapter.

2. WHAT COULD BE THE ROLE OF A HEALTH PSYCHOLOGIST FOR PEOPLE DIAGNOSED WITH HASHIMOTO'S DISEASE?

Although Hashimoto's disease is a fairly common pathology, both the literature summary and the experience with those affected show that it can be termed a neglected area from the viewpoint of practical psychology. Thus, in the last chapter, I would like to focus on potential interventions that health psychologists and psychologists should do, based on the experience in the subject.

There are a number of unexplored areas of research in Hashimoto's disease. Since only the treatment-related quality of life and the frequency of comorbid neuropsychiatric disorders have been thoroughly studied, the relationship to various psychological structures remains unexplored. For example, we have scarce data on the quality of life besides biological indicators and treatments, nor on the characteristics and coping skills required for proper management of the disease. Psychological representations related to Hashimoto's thyroiditis have not been revealed yet, neither the way they can relate to experiences and to the management of the disease. Although the role of stress as a disease-inducing factor has not been confirmed so far, there is no data on how stress can be considered as a triggering factor or how it affects the development of the condition or the course of the disease. Naturally it would be important to follow the examination of the latter issue using longitudinal and logging techniques. Although the disease is often associated with physical changes (tendency to corpulence, dry skin, thinning hair, cosmetic problems, etc.), so presumably body image can also be affected, no studies have been found in the literature related to body image in the context of this topic. Similarly, the disease can strongly affect metabolism and energy levels, but we do not have any data on whether interception-related characteristics can be observed.

Lifestyle (especially diet, supplements and exercise) often occupies an important place in the minds of those affected, however no methodically well-planned research has been carried out that could help navigate the proposed lifestyle. A particularly relevant question is whether a gluten-free diet could reduce the occurrence of the disease, or – in case of an existing disease – reduce the occurrence of the symptoms and/or the extent of the autoimmune processes. Although investigations are taking place in this area (Mainardi et al., 2002; Passali et al., 2020), we do not have enough data, not even on whether it is appropriate to recommend avoiding gluten at all.

In practical and clinical work, we do not know of any system or protocol of care that has undertaken to integrate psychosocial aspects into treatment; thus, the last part of the study attempts to propose such recommendations.

Focusing on supporting the patients concerned, the tasks providing adequate and complex care can be arranged in different phases.

2.1. PREVENTION

There is scarce data on the possibility of prevention, so we can only be very careful in our statements. Since there is an autoimmune process behind Hashimoto's disease, and as with most autoimmune diseases the immune-genetic background of the individual may be important, we cannot influence this kind of vulnerability among risk factors.

However, if Hashimoto's or other autoimmune diseases are known in the family, a general healthy lifestyle, support for the immune system and early screening can be important. Secondary prevention may also include recognition and diagnosis carried out in time: if an individual has other autoimmune diseases or health characteristics (e.g. overweight, PCOS, insulin resistance, celiac disease) that are often associated with Hashimoto's thyroiditis, appropriate monitoring or necessary lifestyle changes should be observed.

2.2. THE PROJECTS RELATED TO DIAGNOSES

Working with patients clearly highlighted that the time around receiving their diagnosis is one of the most stressful periods for them, mainly due to the lack of adequate information. Thus, at the time when the diagnosis is communicated, or within a short period of time afterwards, appropriate education is vitally important. Education should cover a number of areas; the medical characteristics of the disease, understanding the basic principles of treatment, the fact that the person is at the beginning of a process, the possible more complex consequences, and the lifestyle changes that may be necessary. The most important part of education on the medical characteristics of the disease is, of course, carried out by the specialist, but a health psychology consultation is recommendable after receiving the diagnosis. Health psychology consultation offers a longer working period, during which it is possible to deepen the knowledge and understanding of the disease, to discuss concerns and to support the necessary lifestyle changes. It also allows to explore the factors that influence adherence and to increase the motivation for behavioral changes. If comorbid psychiatric disorders are suspected at the time of diagnosis, the health psychologist may also screen for them or transfer the person to a clinical psychologist/psychiatrist. We have seen that comorbid mood disorders are common, which can also be caused by the autoimmune process itself, so it is also important to rule out whether the mood difficulty can be explained by other mechanisms and characteristics.

If Hashimoto's disease is diagnosed as a result of another health problem or difficulty, the health psychology consultation should be adapted to this, for example to help individuals understand the related phenomena in a more complex way.

After receiving the diagnosis health psychology consultation can address the uncertainties related to dieting, make interventions based on scientifically supported results, thus supporting patients, for example with booklets containing basic guidelines on lifestyle.

The consultation can help reducing self-blame for the disease and support the development of an appropriate mental representation of the disease in support of the management of the condition. If the specialist feels that the representations of the person need to be changed more seriously, it may be important to offer a few suitable therapeutic sessions in addition to the consultation.

The primary objective of the post-diagnosis health psychology consultation is therefore to educate, to provide the most accurate knowledge, thereby reducing uncertainty and anxiety, and– through all this process –to increase the self-efficacy and control of those affected.

2.3. PSYCHOLOGICAL ISSUES ARISING DURING THE TREATMENT PROCESS

In case Hashimoto's disease is well-managed, additional psychological help is rarely needed, however, psychological monitoring may also be important due to the development of possible comorbid disorders. Of course, the attending physician often sees the psychological way it works, but some questionnaires can also make his/her work easier. If these patients complete them before the medical visit (even online), it can be quickly attained whether it may be necessary to provide the patient more extensive support. A depression scale or a quality of life questionnaire specifically designed for thyroid diseases are recommended. There are several versions available, the official Hungarian version of ThyPro39 (Quality of Life Questionnaire for Patients with Tyroid Disease) (Watt et al., 2015) is in the process of being translated. Several subscales of the questionnaire indicate whether an area of quality of life is affected – and need for special attention, possibly psychological support. Subscales include Struma/goiter symptoms; thyroid underactive symptoms, thyroid overactivity symptoms, eye symptoms, fatigue, cognitive difficulties, anxiety, depression, emotional vulnerability, effect of the disease on everyday life, effect of the disease on social life, effect of the disease on sexuality (not included in the abbreviated version), cosmetic difficulties and total score (used only for the abbreviated version). The questionnaire has been abbreviated and adapted to several languages (Boronat et al., 2018; Watt et al., 2014).

During the treatment, it can be a critical period when the autoimmune process itself reaches a level that requires special medication and intervention; in this case, the aim may be to manage side effects, to maintain proper adherence, and to strengthen confidence in the patient's health and body.

It is also a critical period if surgical intervention is required due to background processes (e.g. to reduce the autoimmune process or to reduce the chance of malignant processes, or to alleviate symptoms that interfere with everyday functions, for example swallowing). If the attending physician considers that the person has difficulties accepting the need for surgery or is anxious about the procedure, offering psychological support is recommended.

Although it is common for Hashimoto's disease to be discovered in connection with other health problems, it is also possible that this diagnosis is made first, and the person later encounters other difficulties that may be related to underactive thyroid gland, such as insulin resistance, PCOS, fertility problems. In such a case, especially if the patient has already developed a relationship with a health psychologist due to the management of thyroid disease, it is also worth offering further consultations aimed at strengthening resilience among new challenges.

However little is known about the effect of stress, the symptoms themselves, such as uncertainty and the deterioration of the quality of life are definitely associated with increased tension, as with other immunopathological disorders, teaching and supporting stress management techniques can be especially useful. Different relaxation techniques and mind-body therapies can be found in literature, which can help balance the immune system; for example, by reducing inflammatory mechanisms (Bower & Irwin, 2016; Morgan et al., 2014). Due to changes in body and body image, mind-body therapies are particularly recommended, but unfortunately we do not have any data on how effective they are in case of Hashimoto's disease, since unfortunately no psychological interventional effect-study literature is available in this field.

3. SUMMARY

This paper aimed to present psychological correlates of Hashimoto's thyroiditis as widely as possible. Although working with patients clearly suggests that health psychological support may be needed at various points and regarding several issues, these aspects are not emphasized in the literature or treatment protocols. The author hopes that the research suggestions and treatment proposals presented, all based on scientific and practical evidence, will meet with openness by professionals. Hopefully, a more determined observation of the biopsychosocial approach will also be launched in a pathology that has hitherto been neglected from a health psychological point of view.

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Csanád Szabó

PSYCHODERMATOLOGY AND HEALTH PSYCHOLOGY CARE IN DERMATOLOGY

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1. THE RELATIONSHIP BETWEEN SKIN AND SOUL

Psychodermatology is a discipline that studies the interactions between the soul, the nervous system, and the skin, involving four major fields: psychiatry, psychology, neurology, and dermatology (França et al., 2017). Modern psychodermatology relies on the biopsychosocial disease model (Gieler et al., 2020). Several researchers argue that this model should be extended to the spiritual dimension, as both religion and spirituality are of paramount importance for high quality medical training and clinical practice, and this could justify the use of "biopsychosocial-spiritual model" as a term (Saad et al., 2017). The visibility of the skin places dermatology in a special position among clinical areas, and this may make it particularly important to apply a complex psychosomatic approach with patients (Gieler et al., 2020).

2. TYPES OF PSYCHODERMATOLOGICAL DISEASES

Psychodermatological diseases can be classified into four types: psychophysiological skin diseases, psychiatric disorders with skin symptoms, skin diseases with psychiatric symptoms, and other disorders (Jafferany, 2007; Jafferany & Franca, 2016; Jafferany et al., 2020; Koo & Lee, 2003).

3. SKIN DISEASES AND STRESS

Stress can be a trigger for psychophysiological skin diseases and can exacerbate these diagnoses. In addition, the degree of stress may also be related to the level of quality of life in skin diseases (Dixon et al., 2018). How is this interaction created? Psychological stress can have a direct effect on the barrier / protective function of the skin (Orion & Wolf, 2012) and on a wide range of immune parameters that can directly affect the condition of the skin (Gupta & Gupta, 2013).

4. PSYCHOLOGICAL FACTORS IN SKIN DISEASES

Many psychological and psychopathological factors can affect skin patients' level of quality of life. I have collected some of these factors here:

a. Stigmatization.
b. Attachment.
c. Dealing with skin disease.
d. Sleep quality.
e. Sense of coherence.
f. Emotions.
g. Psychopathological factors.

5. OBJECTIVES OF HEALTH PSYCHOLOGICAL WORK IN SKIN PATIENTS

The goals of health psychological support can be very diverse in skin patients. These objectives are summarized in Table 1.

Objectives of psychological support in skin patients
Identification of sleep difficulties.
Reducing the level of distress.
Identification of psychiatric symptoms.
Reducing social isolation.
Increasing self-esteem.
To help patients accept their illness.
To discover what kind of treatments the patient can choose and to help them make their decisions.
To examine what difficulties patients are experiencing due to their skin condition and to gain insight into what factors sustain these difficulties.
Identify useful coping strategies.
Develop social interaction skills.
Investigate what topics are indirectly related to skin disease.

Table 1: Objectives of psychological support in skin patients
(based on Jafferany & Franca, 2016; Papadopoulos, 2005).

6. INTERPROFESSIONAL COOPERATION

Today, many practitioners of psychodermatology believe that in the care of patients who are particularly affected by psychological factors, in addition to the involvement of dermatologists, the work of psychologists and psychiatrists is also important (Azambuja, 2017; Patel & Jafferany, 2020; Šitum et al., 2016).

Finlay and colleagues (2021), as a working group at the European Academy of Dermatology and Venereology (EADV), have collected methods that may help skin patients who have received treatment but still show signs of deteriorating quality of life. Methods and factors that improve quality of life were divided into four groups: dermatological interventions (hospital treatment, involvement of multidisciplinary groups, use of patch tests, and identification of relevant allergens, education); external services (corrective makeup, climatotherapy and balneotherapy); psychological methods (psychological intervention, cognitive therapy, hypnosis); and lifestyle (lifestyle and behavioral changes, religious practice, spirituality, and listening to music) (Finlay et al., 2021). According to the working group, clinicians should consider using these approaches if quality of life deteriorates in a given patient despite the optimal use of standard therapy (Finlay et al., 2021).

7. PRESENTATION OF PRACTICAL EXPERIENCE

7.1. HEALTH PSYCHOLOGICAL SUPPORT IN DERMATOLOGY

I worked for 11 years in the Department of Dermatology and Allergology at the University of Szeged, during which time I also provided outpatient and inpatient health support at the clinic. The work topics, number of sessions, and realized professional goals of the series of sessions can be very different for skin patients; to illustrate this I highlighted the opinions expressed at the closing sessions of the joint work in Table 2.

Highlights	*Patient characteristics*	*No of sessions*
So psoriasis is supposed to be like spiritual armor, I don't know what to think about that. However, dealing with dreams has truly illuminated the spiritual aspects of psoriasis for me. I don't know if that's the effect of our therapy or treatment, but I feel like I'm completely asymptomatic right now. I feel like I have a much greater insight into the mental factors associated with my psoriasis. Thank you for these conversations.	Woman being treated for psoriasis.	6.
As a result of our conversations, I have felt a change in many areas in my life, such as how my attitude towards family members is different. I wasn't upset when I got a parking ticket; I see that as a change. I see that these conversations laid down the basis for me to sit here calmly and thoughtfully at this time and see through certain things and processes. These meetings are reassuring. The good thing is that I have a safe place where I can come to deal with my issues and to talk them out, and this has a good effect on me.	Man treated with erysipelas.	8.

I was relieved at the meetings. Do not stress. Take it easy. Don't react that way, but another way. I became more aware. I should lose 10 kg. I have to figure something out for that. My experience with my dermatologist is good.	Woman being treated for psoriasis.	5.
These meetings were useful… I was able to talk about things I am not used to… things that I am talking about with very few people… Of course we talk at my workplace, but mostly about work.	Woman treated with vasculitis localized to the skin.	6.
There is peace here, and people are paying attention to me. I can imagine the series of sessions would be handholds for me, like a lecture… it has to settle down. Thank you for your honest opinion.	Woman being treated for psoriasis.	6.
These situations, private ones, are more difficult for me than those where I have an illness or I have to come for surgery, because there is a solution for that, but for these there are none… everything is decided in my head. Maybe there is an option to trust more people?	Woman treated with allergies.	7.
I experienced liberation. It was good to talk about it – like taking a bath, when you step out of the tub and a lot of dirt drips from you.	Woman being treated for psoriasis.	12.
I have to learn to do things without any help, for example to walk more with fewer stairs to climb… or to move to a lower apartment. My self-awareness has grown… I realized I didn't think about myself as a hysterical person. I've been fit in the past, so I should slow down. My current goal is to get to the forefront a little bit instead of going for errands, for example.	Woman treated with arthrosis (Articular cartilage damage).	10.

Table 2: Highlights from patients regarding the closing sessions of the health psychology support session series at the Department of Dermatology and Allergology, University of Szeged.

7.2. CASE PRESENTATION AND RECOMMENDATIONS FOR CASE MANAGEMENT

By presenting a fictional case, I would like to highlight some important topics related to the psychological support of skin patients.

In connection with Károly, his dermatologist contacted me; the young man is being treated for outpatient psoriasis at the Department of Dermatology and Allergology, University of Szeged. To his dermatologist, Károly seems unmotivated and tired, which according to his doctor influences the development of his symptoms. The patient is 22 years old, and psoriasis first appeared at the age of 18, when he moved from Szeged to a rental apartment in Budapest. His symptoms initially appeared (red, white-peeling plaques) on the outer surfaces of his limbs, elbows, knees, and scalp. He previously received topical preparations and creams for treatment, and then received light treatment when his symptoms worsened. Nowadays, it is difficult to achieve remission of his disease. The itchiness causes him discomfort, which occurs most of the time at night, and he wakes up two or three times because of the itchiness. Károly was born in Szeged and is currently studying at a university in Budapest.

He finished a BA in Ceramics from the Moholy-Nagy University of Arts and is currently a sophomore in the MA program in Ceramics. He describes himself as an introvert, speaking slowly. Two years ago, his three-month relationship with a woman of similar age in Budapest ended, and his ex-girlfriend said she broke up with him because she found Károly's behavior boring. Currently, he is trying to get acquainted with the Tinder application. It is stressful for him to see how his contemporaries have entered into relationships in recent months, while it is still difficult for him to get to know others. His skin symptoms also affect his self-esteem. He moved back home to his parents' house in Szeged 15 months ago due to the COVID-19 pandemic, and he attends classes online. His parents support him, but it is awkward for him to take part in education from home. When he and his friends went to play tennis, some people in the locker room looked at him strangely because of his psoriasis symptoms. Sometimes it’s hard for him to focus on his university assignments because of the stinging, itchy feelings caused by psoriasis. He experienced his college peers not wanting to shake hands with him because they feared that his symptoms were contagious. Károly said he is afraid of the systemic treatments; he had consulted with his dermatologist and agreed that in some cases their use was medically justified, but he still found them scary. According to Károly, because of his acquiescent attitude, his dermatologist thought he was unmotivated in his treatment because otherwise he would follow the dermatological care. In his high school, he was looking at a door of one of the rooms with the sign “school psychologist” and imagined what it would be like to go in there, but he didn't ask for an appointment. He said at the first health psychology consultation that “it was good; maybe the next meeting will be even better”. He heard about temperaments from an acquaintance of a psychology student who thought he discovered a “slowly warming” temperament. Károly's father is a painter and his mother a history teacher.

7.2.1. BASIC NATURE OF THE SUPPORT

The nature of health psychological support can be fundamentally different when working with an inpatient as opposed to an outpatient. In an inpatient, it may be important not to explore the underlying factors of the symptoms, but to develop a so-called primary experience space (Csabai, 2010). It is important to provide a sense of security by mediating a rhythm, for example with the predictability of hospital events, by turning and reflecting on the patient so that experiences can be focused on, feelings and thoughts can be linked to events, and then feelings can be verbalized through different techniques. In outpatients, if health promotion is needed, a motivational interview can be a useful technique to help change health behaviors (Urbán, 2017). If the patient's spiritual support is the main goal, then education related to psychosomatic connections and spiritual support, as well as work of a basic psychotherapeutic nature, are useful tools for the health psychologist.

With Károly, outpatient support could be provided, for example, by developing the following focus points: improving self-awareness (even by incorporating a quickly administered self-knowledge personality test, such as a 50-item IPIP representation of the Goldberg (1992) markers for the Big-Five factor structure); self-image and body image; working on attitudes towards important people around him (even when assessed using the PRISM-D drawing test (Havancsák et al., 2013), and treatment.

7.2.2. NUMBER OF SESSIONS

It could be important that we inform the patient at the first session how many sessions are planned. Dalgard and colleagues (2020) analyzed the treatments of 50 patients treated in a one-year period in a Swedish psychodermatology care unit. It was found that those who received psychotherapeutic support most often had 1 to 5 meetings with the unit's specialists (Dalgard et al., 2020). Roche and colleagues (2018) analyzed seven-year patient care data for a psychodermatology clinic in Ireland. The average number of sessions in which psychotherapeutic support was provided to patients was 4.3, and the number of meetings in a series of sessions held with them ranged from 1 to 16 (Roche et al., 2018). Urbán (2017) suggested that in the case of behavior that endangers health during clinical health psychology work, 3 to 6 sessions may be required to intensively support behavior change. Based on all this, I conclude that a series of six-session appointments for a dermatological outpatient may be recommended during the first consultation. We were also able to suggest this number of sessions to Károly at our first meeting.

7.2.3. FIRST ENCOUNTER WITH THE PATIENT

It may be worthwhile to take a psychosomatic first interview with skin patients. An important element of this is that the expert maps the possible correlations of psychological events in the interviewees' medical history with their somatic data in such a way that patients have the opportunity to describe these in their own words, largely in the order and time they like (Adler, 1999). The interview scheme is as follows: 1. introduction; 2. providing, as far as possible, comfortable conditions for conversation; 3. (inquiring about open questions) health complaints and the reason for seeking medical attention; 4. examination of current complaints (a. their temporal action, b. their nature, c. their intensity, d. their localization, e. their connection with other complaints, f. circumstances of their occurrence, g. characteristics of their exacerbation and alleviation; 5. possible previous illnesses; 6. health statuses of relatives; 7. personal development; 8. current living conditions; 9. systematic inquiry into symptoms of other organ systems; 10. questions and additions of the patient (Adler, 1999). A psychosomatic interview technique has also been recommended for dermatologists by Tomas-Aragones and colleagues (2017) because it maps the biomedical, psychological, and sociocultural aspects of what a patient reveals. The use of this form of interview can also be useful for doctors and psychologists.

In the case of Károly, the use of psychosomatic interview techniques could offer the main advantage of shedding new light on the effects of psychiatric distress on the symptoms of his psychophysiological skin disease (psoriasis).

7.2.4. FACTORS AFFECTING PATIENT SUPPORT

While holding a clinical health psychology session, it is worth paying attention to our verbalization and the extent of patient self-discovery. Research has revealed an important, stable relationship between the expert's verbalization and the patients' self-exploration: the level of verbalization in a series of sessions has an effect on the degree of self-exploration, and vice versa (Tringer, 2007).

The topics we could address with Károly would also depend on the patient's needs, but based on the case study the following could be discussed in the first session: mood, social network characteristics, psychosomatic connections between stressful situations and skin condition, disease representations, characteristics of doctor-patient cooperation, sleep quality, attitudes towards his profession and university education, attachment pattern, personality traits, psychological effects of the coronavirus epidemic, stigmatization experiences due to symptoms, family habits, and expectations related to psychological support.

Lessons learnt from this case

Looking at the “achieved” psychological goals in Table 2, I found it interesting professionally that sometimes I saw in a similar way what the patient gained from the series of sessions; sometimes I was surprised by what had been said at closing sessions. My way of thinking about psychological support was strongly influenced by the fact that between 2015-2018 I was a central trainee at the SZTE MSc and BTK Applied Health Psychology Vocational Training, and that I trained for four years at the MASZKPTE Person-Centered Psychotherapy Method-Specific Training. Hearing that some patients' ways of connecting with key people have changed, others' personalities have moved closer to the image of a 'well-functioning person' as described by Carl Rogers (Rogers, 1963), and others have reported an understanding of the psychosomatic connections to their skin disease, all made me realize the diversity of health psychological support for skin patients.

8. CHALLENGES AND DEVELOPMENT OPPORTUNITIES IN PSYCHODERMATOLOGY

As we have seen, the science and field of application of psychodermatology have undergone many changes in recent decades. Finally, I present some new development opportunities, directions, and good practices regarding the connections between the soul and the skin.

Zhang and colleagues (2021) developed the Psychosocial Adaptation Questionnaire for the study of chronic skin patients. The 18-item scale tested by 321 skin patients examines three factors: the psychological (e.g., skin problems making the patient helpless), social (e.g., other people making offensive comments about the patient's skin condition), and cognitive aspects (e.g., overall satisfaction). According to the authors, the scale can also be administered in a busy dermatological office and can complement dermatological quality-of-life studies (Zhang et al., 2021).

Ryan and Wagner (2021) argued that it would be worthwhile to establish a one-year psychodermatology scholarship for dermatologists and psychiatrists who have just completed their U.S. residency training, which would also have a positive impact on patients, professionals, and the medical faculty. Hewitt and colleagues (2021) examined the effects of a motivational interview and one-day training for professionals in the United Kingdom to help change behavior in psoriasis patients. Representatives of several professions, dermatologists, psychologists, and nurses also participated in the training, and it was reported that this increased their skills, confidence, and motivation to support their patients' behavioral changes (Hewitt et al., 2021). Psychodermatology seminars were held in the city of Kiel, Germany between 2018 and 2020 as part of an educational program for medical students from the University Department of Dermatology, during which students had the opportunity to learn about skin stress and the biopsychosocial disease model (Wittbecker et al., 2021). In Szeged, the Department of Behavioral Sciences of the University of Szeged organizes education on psychodermatology for medical students within the framework of the course "Theory and Practice of Psychosomatic-Integrative Medicine".

Education creates opportunities for professional collaboration within patient care, which is particularly important in the field of psychodermatology. Initiatives in this direction include psychodermatology clinics, and units have been established internationally in several countries, such as Israel (Orion & Ben-Avi, 2011; Orion et al., 2012), India (Goyal et al., 2018; Shenoi & Prabhu, 2018), Singapore (Chung et al., 2012), the United States (Seale et al., 2018), and Portugal (Ferreira et al., 2019). At the Clinic of Dermatology and Allergology in Szeged, Hungary, three specialists provide health psychological support and conduct research in this extremely diverse field of patient care.

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Part 2

PEDIATRIC CARE

Emőke Salló

HEALTH PSYCHOLOGY IN PEDIATRICS

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I. GENERAL OVERVIEW OF THE FIELD

Clinical care for sick children and adolescents can be practiced by carrying out interdisciplinary team work. Effective work in patient care requires comprehensive developmental psychology knowledge on the part of the healing team, and in addition to the child's chronological age, his or her psychological development and developmental characteristics must also be taken into account. When a disease emerges, it can be stressful for the child to develop symptoms, adapt to an unfamiliar environment, have fearful tests and interventions, and endure painful treatments. Hospital ward examination and treatment sometimes means separation from parents and family members, which can lead to anxiety and fear of being abandoned in young children. Symptoms of regression and mood changes are common among children hospitalized for a prolonged disease or long-term care. Perceived symptoms in most cases do not meet the diagnostic criteria for DSM, yet may lead to impaired functions and in addition to the experienced suffering they may show reduction in active participation needed during the healing process (Bursch & Stuber, 2005). In the care of children, we consider the parent not merely as a source of information whom we have an obligation to inform, but also being trusted with an active role in healing.

Below, I present the process of providing psychological care for children with chronic illness through the example of coping with a common chronic illness, type 1 diabetes (T1DM). Diabetes resulting from autoimmune processes is a model disease in many ways, as the role of psychological factors and coping patterns has a new significance due to the chronic course of the disease. Living with diabetes challenges patients' adaptability and demands self-discipline in their daily lives. The incidence of mental illness among diabetic children and adolescents is high worldwide, which may lead to low glycemic control in the long run (Northam et al., 2004). Among the most common psychiatric disorders depression, anxiety disorders, as well as eating and behavioral disorders deserve special attention. Diabetes-specific emotional distress is associated with negative feelings and specific fears associated with the disease, such as anxiety and depression due to blood glucose values, being overburdened by the day-to-day diabetes management, the lack of social support, or dissatisfaction with medical care (Fisher et al., 2014).

Risk factors that affect the mental health of diabetic children include low emotional control skills, high diabetic distress, and various impulse control and behavioral disorders. Mental disorders or illnesses and conditions associated with intellectual disability, as well as certain personality traits, can negatively affect disease comprehension and compliance. However, underlying childhood compliance problems are often due to an underdeveloped prefrontal cortex, which is responsible for executive functions. Among the environmental risk factors, we need to highlight family conflicts and lack of social support. Joining deviant groups may lead to the emergence of risk behaviors, especially in adolescents. Low socioeconomic status had previously been considered a risk factor in childhood diabetes, but the supply of insulin to children has already become subsidized in public health care, and the provision of dietary meals is required by regulation. Hormonal changes in adolescence affect insulin sensitivity, which can lead to deteriorating carbohydrate metabolism.

Psychosocial changes and the desire for independence by the adolescent may lead to acute situations and adherence problems. In adolescent diabetics, a number of difficulties related to age and life circumstances are associated with distress, such as family conflicts over diabetes management, parental overprotection and overbearing, dissatisfaction with one's body image, degree of independence and responsibility in diabetes management, and fear of the future (Hessler et al., 2016; Markowitz et al., 2012). Adolescents whose parents allow them full independence in diabetes management without adequate cognitive and social maturity are more likely to face deteriorating metabolic problems (ISPAD, 2018).

2. CASE STUDY

In the case study, I present the psychological changes and intervention options in the care of diabetes through the example of a fictitious person created by combining several similar cases in order to protect patients.

2.1. PRESENTATION OF THE PATIENT, CONDITIONS OF DISMISSAL

I first met 15-year-old Kata in the diabetes department, where she stayed for a few days for reeducation and prevention because of non-adherence problems. Due to the nature of the problem that warranted her admission to the hospital ward, her doctor requested psychological counseling for her. Having received the consent of the patient and her parents, I looked for a quieter place in the ward to talk to Kata, where I tried my best to create a safe therapeutic atmosphere for her.

Kata is a tall girl, she has an average body type and brown hair. Her behavior was conventional, but she was a little tense in a situation strange for her. She was responsive and cooperative in the conversation, but at times showed signs of anxiety and sadness. realizing that I restrained from judgement and feeling my empathetic acceptance, her tension eased, but she was reluctant to talk about her difficulties, and she had a hard time sharing her emotions.

Later, I had the opportunity to meet her mother, who was really worried about her daughter. She gave the impression of an organized, rational woman who was always polite. After the conversation, I sensed that she wanted to distance herself from her child's current difficulties. She made her child responsible for the current situation, which made me feel uncomfortable, so I sympathized even deeper with Kata.

2.2. CURRENT PROBLEMS, DIFFICULTIES

Her doctor found higher blood sugar levels and elevated HbA1c levels in a standard follow-up test, which may have occurred due to irregular insulin administration or increased carbohydrate intake. Kata's behavior had changed lately: she became unmotivated, anxious, deprived, seemingly uninterested in diabetes management, and isolated in the community. Her parents tried to apply even stronger control over diabetes management through ongoing monitoring. Her doctor reacted empathetically and helpfully to the problem, recognizing that she used to be an obedient, mature girl before, and the reason behind the changes could be related to emotional difficulties.

2.3. ANAMNESIS, PRESENTATION OF SUBJECTIVELY PERCEIVED SYMPTOMS, RELATING TO THE PROBLEM

Kata is currently in the 9th grade, studying in an urban high school to which she was admitted with a high score. During her elementary school years she was a good and hard-working student, with good abilities. She had been looking forward to high school very much, and she expected to find friends and classmates with similar interests. The boys from her elementary school embarrassed her and bullied her for years because of her diabetes and her outstanding academic performance. They thought that Kata would be favored as she had been acquitted from physical education, or because she had been allowed to eat during classes, which was forbidden for others. Bullying and the void of sympathy filled Kata with sadness and frustration; she tried to avoid social situations, and she immersed herself in studying to escape from community activities. She has not yet been able to integrate into the current, new class community, and due to her marginalized role, she has no friends and maintains good relations with only a few classmates. Her grades are still very good; she spends almost all of her free time studying. Her family maintains high expectations regarding her school performance. Her parents work a lot; her older brother didn't disappoint them with his excellent results. At home, Kata was given the role of the perfect child, who "just" had to study well and help with household chores whenever she had been asked. She describes her mother as a perfectionist, controlling person. Kata is emotionally closer to her father, and she can turn to him more often with her problems. Decisions about upbringing are usually made by the mother, and the father sometimes tries to soften the stringency. Her relationship with her older brother is superficial, she feels that her parents give her brother more autonomy and freedom, and trust him more.

After an infection which she had contracted when she was 7 years old, she was diagnosed with diabetes. Due to the infection, and with the emergence of diabetes symptoms, she lost weight significantly and she became anorexic and easily tired. The fact that the family had to face diabetes hit them unexpectedly and as a shock. Her mother, approaching the crisis situation in a problem-oriented way, tried to gather the necessary knowledge so that they could continue their lives at home. The parents initially tried to protect Kata from the truth, not telling her what her disease was. Kata tolerated the needles and dietary restrictions, hoping she would recover. Her understanding of the disease developed gradually and continuously, and regular medical check-ups provided her with information appropriate for her age. She acquired the necessary knowledge in diabetes management and had already gained independence as an elementary school pupil. Coexistence with diabetes became part of her everyday life, and she accepted the changes in her life and tried to adapt to them.

Towards the end of the 8th grade, seeing her classmates aspiring to be increasingly independent, she experienced a feeling of being restrained because of her disease. She saw her condition as a disadvantage, a restrictive way of life that deprived her from being liberated. She said that she had had experienced depression and the sadness due to being lonely in the upper grades of elementary school.

In the secondary school, starting in 9th grade, her rebellion coincided with the normative crisis of adolescence that materialized in diabetes management. She secretly bought high-carb candies, and consuming them made her blood sugar level fluctuate. Due to high blood sugar levels, she had frequent headaches and difficulties in concentration. She was unable to prepare properly for her tests, and her performance deteriorated. Performing at a high level at school was an important part of her self-image and identity, so when she could not cope with experiencing failure, she became tense and anxious, and her self-esteem decreased. She became even more isolated in the community, her mood became more and more depressed, and she sometimes secretly tried to relieve the emotional tension and pain she could not stand by self-inflicting wounds. She reacted to the problems by becoming helpless and depressed; she felt no one understood her.

Hypoglycemia was becoming more frequent in her as a result of fluctuating blood glucose levels and school performance anxiety. Once, while writing a test at school, she experienced malaise intensively, similar to a panic attack due to her low blood sugar. Since then her safety concern had intensified, became more cautious, further reinforcing her belief that she needs to keep her blood sugar levels high so that her malaise does not reoccur. As a result of the malaise, her new classmates had also become aware of her illness, which she had tried to keep secret because she feared that she would be bullied and mocked in her new community as well.

Her parents, when they noticed the problems, banned her from taking part in community activities, controlled her diabetes management and eating even more strictly, which led to frequent friction and tensions in the family, especially straining the mother–daughter relationship. They tried to conceal the elevated blood sugar levels from the outside world and the healers, in the hope of being able to take care of the problem domestically. However, a three-month diabetic follow-up study revealed a higher HbA1c level and immediate treatment was recommended by members of the healing team.

2.4. RELATING TO ILLNESS, RECOVERY, HEALTH CARE. HOW MOTIVATED AND ABLE IS THE PATIENT TO WORK TOGETHER, TO INDUCE CHANGE?

Kata initially refused the opportunity to be admitted to the hospital, arguing that she would fall behind with her studies in the middle of the school year if she missed school for a few days. She downplayed the problem, locked herself up, and tried to find a solution on her own. She politely attended the training of the dietitian and the education nurse, but tried to escape the conversations that were unpleasant for her as soon as possible. Psychological counseling initially took place in the same manner. Validation of her emotions, unconditional acceptance, and honest communication provided an opportunity for her to be able to articulate her difficulties, which resulted in her distance being reduced somewhat.

Family tensions were identified by her as a primary problem which increased during everyday diabetes management. She sees any change in her relationship with her parents as hopeless; she herself drifts helplessly between expectations. In this inevitably vulnerable state, the use of limited parental re-care (a schematic method in which we try to satisfy a patient's emotional needs with a sincere, accepting, intimate, caring attitude similar to that of a good parent, but within a limited range of adopting therapy) allowed her to accept the psychological help offered, proven to establish a therapeutic alliance in the long run (Vizin & Farkas, 2020). The assistance offered focused on finding common solutions to adherence problems. Kata was able to self-reflect and had insight into the problem. The resources of her personality which had been aware of–good intellect, compliance, and discipline–made me feel confident in the prospective success of our working. Her motivation could be identified in reducing suffering, restoring emotional stability, and improving interpersonal relationships.

2.5. PRESENTATION OF INTERVENTIONS AND CHANGES IN THE PATIENT DURING THE PROCESS

We initially entered a contract with Kata and her parents for 15 appointments, to which three additional parent consultations were added. The health check conversation allowed us to get a thorough picture and jointly understand the problem that affected her mood and diabetes management, and to jointly formulate the goals of working together. Prior to the contract, I consulted her mother in a separate consultation because I really wanted her to be involved in the process. During the conversation, I sensed the mother's guilt and shame for not being able to raise her daughter in a way when adherence problems would not surface. The mother accepted the possibility of parental consultation, which focused on understanding how Kata is experiencing her illness and the challenges she is facing in her current life situation, and how the mother can help Kata while improving her relationship with her child. From the consultations, I hoped that if the mother managed to feel empathy and acceptance for her daughter, she could find better solutions to help her effectively.

As a first step, Kata and I undertook to explore the link between glycemic control and anxiety. Psychological interventions were aimed at mapping the psychological processes underlying the fear of hypoglycemia and reducing anxiety. The trigger was the experienced hypoglycemia during a school test, which was associated with anxiety and fear. Later she mistakenly identified the occurrence of vegetative symptoms of anxiety with signs of hypoglycemia. Psychoeducation aimed to enable her to differentiate between real and deceptive symptoms in the relationship between hypoglycemia and anxiety. It was also part of the education to make her understand the effects of stress on her blood sugar level and how mood and frame of mind affect blood sugar levels. Increasing awareness of the combined effects of diet, insulin administration, and exercise, which contribute to better physical and mental health, was also used to regain her control over diabetes.

Psychoeducation alone did not bring about a change in diabetes management, but it did contribute to a better understanding of the disease, which somewhat increased Kata's sense of being in control. The change required mapping and cognitive restructuring of negative automatic thoughts related first to hypoglycemia and then to school anxiety, to reduce her anxiety as a result of more realistic, adaptive thoughts. She realized that her avoidance behavior – keeping her blood sugar high and eating food containing a lot of carbohydrates – did not contribute to reducing her symptoms. Activating Kata's role in diabetes management and continuing to support it further increased her sense of control and reduced her anxiety. We set short-term, well-defined, realistic and achievable goals that did not impose an additional burden on her, but still led her to achieve success. Her attempts were not always successful, which provided an opportunity for us to discuss that stumbling is not the same as a relapse. She became able to exercise control over her illness, becoming more independent, and not only did her blood sugar levels improve, but her mood and temper also improved.

At the parent consultation, we also focused on activating Kata's role, while involving the parent to take an active part in creating an agenda that helps Kata to plan and perform her daily exercises. The mother took part in going along with Kata to swimming classes three times a week, which, in addition to having a positive effect on blood sugar values, also provided an opportunity for them to get closer to each other. We also explored the topic of shared responsibility, in which the mother recognized her own role but refused to give up the idea that her daughter should behave much more responsibly. She was still not open to understanding Kata's struggles, nor did she appreciate her efforts.

After 15 occasions, we evaluated the results of our work together. In addition to the gradual results, Kata felt a need to continue working on her problems, so we prolonged the contract for 30 more appointments, with a focus on coping with the disease and improving the regulation of her emotions.

In the next phase, we examined accepting the stages of the disease, and Kata realized that her behavior had previously been dominated by disregard. Because the anxiety she felt about living with diabetes and the angst due to the bullying by her classmates were intertwined, she tried to ignore both, making her unable to express any feelings about her experiences for a long time. In connection with the processing of her experiences in primary school, she began to feel more and more anger towards the boys who bullied her, and later the same feeling appeared in connection with her diabetes. The feeling of anger brought to the surface the pain of losing her health, but despite her suffering, her numbness and helplessness dissolved, and she became able to express her emotions. Her desire to regain self-esteem was stronger than ever, so we continued to process the mental burdens and injuries caused by the bullying. In the meantime, she mastered relaxation techniques, which provided additional effective help in reducing anxiety and increased her self-awareness. She became more and more capable of self-reflection, beginning to recognize her mood swings.

By this time, we had been working together for more than a year, and although she had achieved significant results in the process of accepting the disease and managing diabetes, she still remained alone in terms of social support. She could not get closer to her classmates, she could not establish friendships. Despite her excellent academic performance, she felt inferior, which she sought to compensate with perfectionism, failure avoidance, and increased control. Though she continued to require support, the frequency of our meetings was reduced to one appointment in two to three weeks. During the summer holidays, however, her mood deteriorated rapidly, because she didn’t have to study, she couldn’t really occupy herself, and she lacked the joyful activities in her everyday life. Her parents still didn’t allow her to attend programs on her own because they didn’t trust her to take proper care of herself. As a result of the isolation, her depression increased, she became unmotivated, her circadian rhythm was upset, her self-esteem deteriorated, she reverted to self mutilation by cutting her skin again, and suicidal thoughts reappeared.

In this situation she was able to recognize her condition and the supportive therapeutic relationship allowed her to seek help. After a rapid assessment of her health situation and with the involvement of a child psychiatrist, it became possible to examine the mood changes after having been admitted to a ward, and after the diagnosis of a moderate depressive episode was established, medication was prescribed.

The emergence of her depression resulted in another crisis in the family, with a minor conflict with her mother who by no means wanted her daughter to go to a psychiatrist. After Kata's admission to the psychiatric ward, during a discussion with her mother it was revealed that she felt ashamed of her daughter's depression, which originated from the negative feelings and beliefs about the history of psychiatric patients and their treatment in her own family. We worked on these feelings with the mother for a long time, until she was able to separate her own difficult feelings from the feelings about her daughter and see her child in her own, discreet reality. Through her insights, she began to see her daughter's personality in a more and more realistic and detailed light. Her empathy for her daughter increased and she was able to handle conflicts with her adolescent daughter more and more effectively.

In the end, Kata and I worked for another two years until she graduated from secondary school at the age of 18. It became necessary to provide support for her more regularly and set new goals in the therapy because of her depression. As a result of the medication as well as her mother's change of attitude, her mood improved and she became more balanced. Developing social skills increased her adaptability, but she had still not been able to build close friendships with her peers.

The breakthrough was achieved in a camp for diabetic children the following summer, where Kata was finally able to become a carefree child among younger children and played along with the 12 to 14-year-olds. Friendships formed in the camp proved to be long lasting, and through these relationships she began to open up, to accept her "imperfections". As an older, clever, maturing girl she was also given simpler leadership roles, which also benefitted her self-esteem. In an accepting, safe and friendly atmosphere, she had the opportunity to notice the struggles of other diabetic children and understand that others were facing similar difficulties. Realization brought her relief, and she was finally able to relax her strict expectations of herself.

Over time, her personality matured, she was able to develop more relations with friends successfully, which came as a surprise even to herself. She was no longer ashamed of the use of the pump and sensor among friends, she was able to successfully represent her interests and took care of herself. Her blood sugar levels were in the safe range, with no complications. Her academic achievements continued to strive matching her abilities, but she was less performance-focused, relieved by her convulsive endeavors, and overall she became more liberated and happy.

As a graduation gift, she asked her parents to allow her to have a tattoo which was in the end approved by them. The tattoo depicted a T1 symbol which is worn by people with type 1 diabetes as a badge. Her adaptation to the disease was expressed in this symbol, which she wore proudly.

2.6.CLOSING AND SUMMARIZING THE CASE

Kata's case highlights that the particular difficulties of chronic diseases are intertwined with the emotional problems due to the characteristics of social development in childhood and adolescence in the background of adherence problems. It has to be noticed during the treatment of chronic illnesses that on the road leading to adaptation we have to take both the development of personality and the formative effect of the environment into consideration.

The expertise and empathy of the healing team made providing psychological help available after recognizing the emotional problems. During the course of psychological counseling the foundation of the therapy requires building confidence, empathy and unconditional acceptance. The process needs to be based on honest and supportive communication, and should be made transparent, setting its goals should be shared, to enable gradual personality and health development changes. In the process, Kata was supported by the emerging results in reducing anxiety and regulating emotions to regain control of her health and to be able to take an active part in self-care.

Psychological intervention was primarily focused on strengthening adherence, which played a key role in establishing better physical and mental health. With the help of supportive techniques her self-esteem was improved, efficiency and confidence were increased, and her ability to adapt was improved. Monitoring changes in her mood, recognizing a depressive episode, and providing child psychiatric care allowed for effective treatment of the disease and contributed to preventing complications.

It was again instructive for me to recognize that it is worth involving parents closely in the therapy of their children, thereby supporting the consolidation of positive turns in everyday life along with the development of parent-child relationships. The shared responsibility between parent and child leads to an increase in adherence in childhood. From adolescence onwards, the gradual assumption of responsibility and self-care by the child, the non-intrusive presence of parents, self-efficacy and at the same time the emergence of the adolescent's independence lead to better physical and mental health.

3. DISCUSSION

In pediatrics, the treatment and care of patients in a bio-psycho-social-spiritual approach is of exceptional importance. Based on international experience, early detection and treatment of psychiatric disorders associated with injury, life-threatening and chronic illness is possible through regular psychological consultations and pre-planned screening. Assessing psychosocial factors and identifying disease-specific distress can play a significant role in the prevention of mental disorders. In order to make the screening tests more efficient, it is necessary to develop and validate the Hungarian adaptation of the individual disease-specific questionnaires.

In the case of administering interventions inducing significant pain, it may be effective to incorporate anxiety management into the pain management program (Sheridan et al., 1997; Stoddard & Saxe, 2001). The introduction of prevention programs and psychoeducation could lead to a reduction of the emergence of anxiety and depression in examinations and interventions associated with significant distress and pain. In Hungary, a storybook called *The Courage Test* for children suffering from leukemia or cancer and for their parents is aimed to support them in coping the disease. *The Courage Test* helps the child to adapt to hospital conditions, to understand the disease, and to prepare for the expected examinations and interventions. Protagonists with similar ages, symptoms and their fabled stories could help children to empathize with these fairy-tale heroes. Studies have shown that observational learning reduces children's anxiety and increases cooperation when seeing a child of their age on video successfully coping with a difficulty (Melamed et al., 1978).

Playing together with a parent, even in a hospital ward, also helps to overcome the frustration and anxiety that comes from vulnerability and helplessness. The contribution of the "Clown Doctors" is also invaluable in reducing the suffering pressure of small patients. During children's recovery time, play therapy, fairy tale therapy and art therapies can be well integrated into the hospital treatment process, which gives young children the opportunity to process stressful experiences and learn new and more effective coping strategies.

In the event of loss of health and life-threatening conditions, crisis support should be available not only to the sick child but also to their parents and siblings. In this situation, it is important for the siblings to have an age-appropriate explanation of what is happening and to have an emotionally accessible adult nearby who can be temporarily be present in the children's lives, answer their questions, and support them.

In the case of diseases that cause permanent damage to health, informing the child's environment and, if necessary, educating them is essential. The importance of social support is highlighted in a study which found that high levels of social support from classmates reduced depression levels in chronically ill children (von Weiss et al., 2002). The empathy and cooperation of peers could be increased if they are educated according to their age and knowledge about their classmate's illness. Nationwide, doctors treating chronically ill patients in clinical centers, many non-governmental organizations and peer support communities organize educational programs in schools and kindergartens. Sick children themselves and their parents need – in addition to the psychological counseling available – peer support communities, where the inspiring and hopeful examples of parents and children who have experienced and coped with similar difficulties can guide them and give them strength to move forward.

Lessons learnt from this case

The first encounter of a sick child with the healing team is a decisive experience in which the healers' supportive, empathetic attitude can minimize the child's anxiety and facilitate the adaptive coping needed for healing, which will later become a cornerstone of health behaviors.

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Ildikó Danis

INTERDISCIPLINARY TEAMWORK AND SYSTEMIC CARE IN PEDIATRIC PSYCHOLOGY: FOCUS ON EARLY CHILDHOOD

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1. INTRODUCTION

Several *chronic childhood illnesses* become evident at birth or during the first months of life, so parents have to cope not only with the natural crisis of parenthood (see Danis, 2020 for more details) during early childhood, but also with the daily tasks related to the sick child, medical interventions, hospital stays, or separation, etc.

The early childhood period can also present a range of difficulties in *the regulation of states, emotions and behaviors* (e.g. *excessive crying*: Long, 2004; St. James-Roberts, 2012; *problems falling asleep and staying asleep*: Bower & Ray, 2006; Mindell et al., 2010; *eating disorders:* Chatoor, 2009) that can be associated with physical symptoms, which drive parents to health care. These symptoms are remarkably common, affecting 5-15% of the infant and young child population (Hédervári-Heller, 2008/2020; ZERO TO THREE, 2016/2019), and may involve interactions of organic and psychosocial, relational influences in both etiology and observed symptom functioning.

The diagnostics and treatment of eating disorders (which is the main topic of our case study) is of great interest in international practice and now in Hungary too. Since the etiology of eating disorders is complex and different types of eating problems can be identified (e.g. Chatoor, 2009), this differential diagnostic process also determines how an effective treatment plan is set up, which in most severe cases can only be achieved through *interdisciplinary teamwork.* The timing and targeting of interventions is key: the most effective methods are complex, systemic, family-centered care that must be provided as early as possible and can be delivered in both primary and specialist care.

Today, interdisciplinary teams are working effectively in many areas of pediatrics (e.g. eating disorders, chronic pain, diabetes management, physical rehabilitation). Multi-, inter- or trans-disciplinary teams (Choi & Pak, 2006) involve several health specialists (pediatricians, psychologists, nurses, clinical social workers, dieticians, developmental therapists, etc.) working together. Usually, during the diagnostic process, each specialist assesses the child and his/her family and then they jointly develop a treatment plan. Each professional offers the services that they are qualified to provide to the family. Ideally, this is integrated into a comprehensive treatment plan. Interdisciplinarity therefore no longer just means that, in a good case, a number of professionals are working "under the same roof" towards the same goals, but also that these goals are shared and there is intensive collaboration for the benefit of patients. There can also be some crossing of professional boundaries, and in *transdisciplinary work* there can be a high degree of shared competences, and tasks can be delegated, and information can be represented and passed on to the family in a uniform way by different professionals.

In *family-centered care (FCC;* for more on the concept, see Mikkelsen & Frederiksen, 2011), care is organized around the whole family. FCC is, to the best of our knowledge today, the most effective way to care for sick children. In the *family-centered therapeutic triad*, the child, his/her family, and the care team work together, and this system is integrated into the wider social environment (Kazak et al., 2002).

From the beginning, pediatric psychology has used *family-focused interventions.* General systems theory inspires the use of the theoretical frameworks of transactional theory and social ecological models, and the use of a variety of systemic and family therapeutic approaches (Mullins et al., 2014). During infancy and early childhood*, parent-infant consultation and therapy* (see for more details Hámori, 2020; Hédervári-Heller, 2008/2020; Hédervári-Heller, 2020; Németh & Hédervári-Heller, 2020) can also provide a systemic and attachment-based form of care that can effectively address most early childhood interaction problems with physical and behavioral symptoms.

2. OUTPATIENT HOSPITAL MANAGEMENT OF FEEDING AND GROWTH DISORDER THROUGH FAMILY/PARENT-INFANT CONSULTATIONS AND INTERDISCIPLINARY TEAMWORK

The following is a fictitious case used to illustrate the possibilities discussed in the theoretical introduction through the work of a clinical health psychologist with families of infants and young children attending pediatric wards. In the case study, the general characteristics of several cases, possible forms of support, and the dilemmas and obstacles encountered in working with families, as well as possible solutions will be presented focusing on the role of the psychologist. A description of the general activities of the psychologist before presenting the case helps to put the care provided into context. In this fictional case study, we aim to present outpatient, interdisciplinary treatment options for a type of early eating disorder.

2.1. PEDIATRIC PSYCHOLOGIST IN A HUNGARIAN HOSPITAL

In the second half of the 2010s, the Department of Internal Medicine and the Department of Gastroenterology of a Budapest children's hospital collaborated providing interdisciplinary care for, among others, early childhood feeding disorders. The team consists of pediatricians (internists and gastroenterologist specialists and practitioners), a dietician, a psychologist, a parent-infant/young child consultant, nurses and a physiotherapist. The practicing health psychologist with a background in developmental psychology, couple and family therapy, and parent-infant consultation volunteers to carry out duties in the department, which usually include:

- *Management of emotional and behavioral difficulties caused by acute illnesses during hospital stay (parent, child, and parent-child consultations at the bedside; parent-physician-psychologist team collaboration).* As part of the daily operations, the psychologist consults several times at the bedside with parents, families, or even with children separately after permission by the parents, (e.g. in times of forced separation, regular age-appropriate "visits" are a particularly important form of support for children: talking, playing, drawing together, etc.). At the morning staff meeting, the medical team indicates which inpatient children and their families should be visited. Sometimes the parents indicate that they would like to talk to the psychologist, sometimes the doctors and nurses request that the psychologist visit a child and his/her parents. The psychologist is always introduced to the parent by the doctor who then explains his or her point of view on why he or she feels a brief consultation is appropriate. If the parent agrees, the psychologist will talk to the family at the patient's bedside or, where appropriate, with parental permission, a brief consultation with older children and adolescents. In the case of young children, the parent is present in every case, except if they are forced to separate due to their living conditions. Methodologically, these short 15–25-minute sessions consist of short supportive talks, emotional support, information transfer, psychoeducation, games, drawing, etc. The topics are mostly related to the child's development, behavior, care or the parent's emotional states and concerns. The consultation focuses primarily on the illness and its treatment, but general developmental and family functioning issues may also be raised. In case a piece of information emerges in the discussion that the psychologist thinks it needs to be shared with the doctors or nurses involved, he or she will ask for permission to share this information and, if possible, encourage this in a parent-child-physician-psychologist team, acting as a mediator. If, together with the doctor, they consider that more than one consultation after hospitalization is warranted, he or she will offer parents outpatient appointments or encourage them to seek out another professional or institute.
- *Periodic management of chronic illnesses in the ward (parent, child, and parent-child consultations at the bedside; parent-physician-psychologist team collaboration).* Sometimes young children with chronic illnesses (e.g. young children with cystic fibrosis awaiting lung transplantation or children with chronic digestive or respiratory problems) and their parents return to the ward and are met by the psychologist on several occasions. In these cases, he or she provides emotional support and talks to parents and relatives about issues of development and the home management of the disease,

and also interacts with the children in a playful way. In cases of increased parental or family psychological difficulties, he or she offers outpatient and other psychological support.

- *For infant and toddler regulatory problems (e.g. feeding disorders, sleep disorders, chronic crying, restlessness), weekly outpatient parent-infant/young child consultations or family therapy as part of the work of the team.* Care for young children and their families is provided by doctors, dieticians, physiotherapists, and nurses who work in a team. The psychologist, following a medical examination, mostly provides parent-infant/young child consultation or family therapy for various (e.g. infantile anorexia, sensory food aversion and illness-related or post-traumatic food refusal) eating and growth disorders (e.g. Chatoor, 2009; Scheuring et al., 2016). A fictional case illustration of this work is presented below.
- *Conducting intervisional case discussions in a doctor-psychologist team.* Case discussions on dilemmas, questions and concrete actions to be taken regarding the etiology and treatment of different early childhood psychosomatic disorders are held between the psychologist and the doctors interested in psychosomatic disorders.
- *Psychological support for the professionals providing care.* In some traumatic cases or in cases of severe psychological exhaustion, the psychologist is also consulted by the professionals working in the department. Short support sessions are then held, either individually or in groups. If there is a risk of burnout or suspected post-traumatic stress, external specialist help is recommended.

3. FICTITIOUS CASE OF A HOSPITAL OUTPATIENT

Twenty-two-month-old Zalán and his parents (Zsuzsa, 32, nursery teacher, Bálint, 34, carpenter) live in a small village in Nógrád county in modest circumstances. Zalán is visiting a dermatologist at the hospital because of a prolonged skin infection that is difficult to cure. During the routine physical examination, the dermatologist notices Zalán's thinness and advises the parents to consult the interdisciplinary team of the department of internal medicine, who investigate and treat feeding problems in both in- and outpatient setting.

At the first consultation, the family will meet the pediatric internist and the health psychologist working in the department. The meeting takes place in an outpatient room furnished with a play mat, toys, and comfortable chairs. The pediatrician in charge of the team indicates that the experience of the first consultation will be the basis to determine exactly what examinations to expect and which specialists will deal with the symptoms by the team. To this end, in addition to a routine physical examination, the team will first ask medical questions about Zalán's current and past development, health, feeding history, and then ask the psychologist to take a more extensive anamnesis to clarify symptoms, parental attitudes and behavior, and the relationships in the family.

Given the rapid movements, highly active temperament and lean physique of the young child, and the history of feeding, infantile anorexia syndrome (see box), a kind of feeding disorder, is deemed highly probable. It is based on a diagnostic system that has been used abroad for decades but is less well known and hardly used in Hungary (Chatoor, 2009; DC:0-3R: ZERO TO THREE, 2005).

Infantile anorexia

Infantile anorexia syndrome usually appears in infancy and early childhood (typically between 6-36 months of age). The infant/young child regularly refuses food and shows no interest or curiosity in eating and food. He/she may run away from feeding situations or it may be impossible to bring him/her into a feeding situation (runs, does not sit down at the table). Parents often seek help only in case of a growth disorder. Symptoms often include increased alertness and curiosity, general restlessness, hyperactivity, and sleep disturbance. In the development of feeding, the transition to independent, patient spoon- or pinch-feeding is one of the most typical times of onset. Dietetic studies most often show that the intake of food is not age-appropriate in terms of quantity and quality, and physical and laboratory tests often reveal deficiencies. In accordance with the diagnostic criteria, stagnation of weight gain followed by a fall of two major percentiles over a period of 2-6 months is typical. Children are smaller, more fragile and thinner than average, while their head circumference is appropriate for their age. Feeding difficulties are not usually due to organic disease and are not related to a traumatic experience involving the oropharyngeal or gastrointestinal system. Children are active, curious, and very sensitive to external environmental stimuli (sights, sounds, etc.), which can distract them from eating. They typically do not notice and thus do not signal that they are hungry. It seems from their parents' accounts that 'everything else is more important to them than eating'. Because of regular food refusals, parents usually use a variety of distraction strategies and sometimes force-feeding to make up for the amount of food they clearly lack. Most of the time we also see family dynamic consequences: not only the child and parents, but the whole family is affected by the “fights” and frustrations around meals.

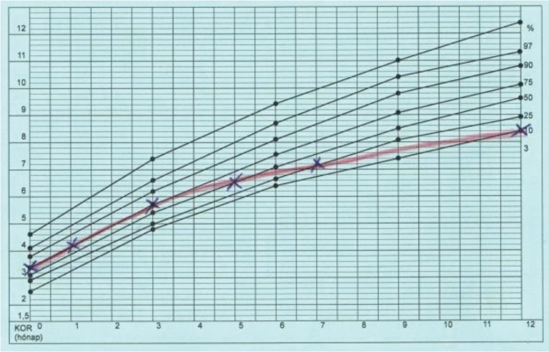
It is assumed that feeding disorders are clearly caused by temperamental characteristics (overactivity, irritability, difficulty in calming down), immaturity and sensitivity of the nervous system, and problems with the regulation of internal body sensations (e.g. hunger, satiety). The infant/young child is more interested in and attentive to external circumstances and environmental stimuli than to internal bodily “messages”. The key to solving this problem, in addition to medical and dietary considerations, is to promote parent-child interactions linked to daily interactions (care situations, play) and specifically to eating. Psychological consultation focuses on reducing anxiety in both the child and the parents, child resistance and parental coercion or abandonment due to inertia, frustration-induced scenarios and fights about eating, in addition to creating predictability in the daily schedule and meals, recognizing the power of shared meals, and setting behavioral limits and frameworks (sensitive discipline). (Chatoor, 2009; ZERO TO THREE, 2005; also Scheuring et al., 2016)

After an educational summary of the symptoms, parents anxiously recall how they have always felt “something was wrong”, how Zalán has always eaten too little and was “tiny”. He was always on the move from the time he started walking, he was running, messing around, asking questions, "always misbehaving" and it has hardly been possible to make him eat. This behavior and the low intake of food were reported to the pediatrician and the nurse, who advised them to be patient, as the child was showing age-appropriate behavior in terms of vitality and psychomotor development. Zalán accepts food at the nursery (which he has been attending since he became 16 months old), but there, pureed food is common, and he does not eat independently yet. At home, he sometimes accepts solid food, but always eats very little. He just runs around all the time, he is busy playing. He may refuse food all day or only take a bite at a time. It has become the habit of his parents to put snacks (small biscuits, puffs, millet balls, crackers) on the table and Zalán takes them whenever he feels like it. "So at least he eats something," says the mother sadly. They rarely sit down together at the table. On these occasions, Zalán starts to eat, but if anything disturbs him (whether it is the dog barking or the siren of an ambulance outside), he stops eating immediately and runs to look out the window.

At 22 months Zalán weighed 10 kg. He was born at 38 weeks as a healthy newborn, weighing 3390 g. His mother had a difficult start with milk, and for the first few days she supplemented his breast milk with formula, until her milk completely ran out at 5 weeks. From then on, they switched completely to formula, which Zalán always ate a lot of as a baby and still eats in the morning and evening.

At six months, he started to eat mashed food and his parents said he was eating well (he would sometimes even accept large bottles). At 12 months, he weighed 8 kg. Figure 1 below shows that Zalán's weight decreased steadily during the first year of life and by the age of one, he was only in the 10th percentile. Shortly afterwards (at 16 months) he went to nursery, and since then, he has not really accepted food at home, and his weight has continued to fall below the expected weight: he is now well below the 3rd percentile curve (Figure 2), so there is a clear problem of weight gain. He appears to be active and vital, with no physical problems apart from being thin. However, it turns out that he never has solid stools. Zalán is very "active and strong-willed" according to his parents, and he is constantly demanding to be with his parents from infancy and is fiercely resisting anything that is not done the way he wants it to be done.

Parents seem motivated and engaged from the very first moment. The father says he was a similar child: "a spoonful of soup, a run around the house, that was the custom in the village", as his relatives used to say. They used to live far away, in Baranya county, where they both come from, but five years ago, at the beginning of their relationship, due to the father's job (at a large carpentry workshop), they moved to Nógrád County. They have no help around here, but they visit their parents whenever they can, because they all like to be with them.



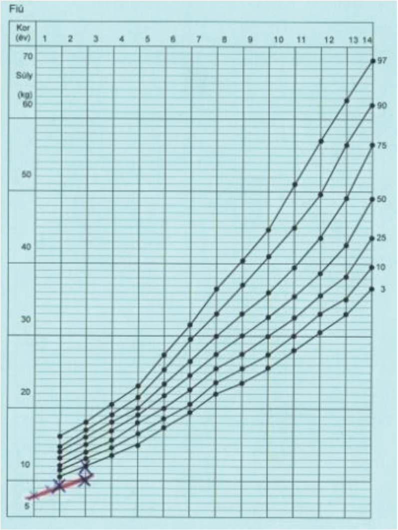


Figure 1: Changes in Zalan's weight in the first year of life, then at one and almost two years of age

After the first appointment, the doctor informs the parents about the medical examinations that will be carried out in the next two weeks. There is no need for inpatient care; the child will continue to receive care on an outpatient basis. The psychologist asks the parents to keep a detailed four-day food diary (two days at nursery, two days at home), recording the time, duration, type, and quantity of each meal and asks for the cooperation of the nursery teacher in writing to do the same. It is agreed that the parents will send the diary by email, which will be analyzed not only by the psychologist and the doctors but also by the dietician colleague, who is expected to be involved in one of the consultations. The parents are hopeful that Zalán's feeding and growth will soon improve.

At the first meeting, the relationship between the mother and the father seems to be harmonious, supportive and a source of strength for each other in their daily lives. Their relationship and their caring attitude and concern for Zalán are an important background for successful work. They are worried and uncertain about how to reverse the process, and openly rely on the help of doctors and psychologists. Their problem-solving skills, mobilizable peer support and positive outlook bode well for their prognosis, even though according to literature, creating a lasting solution to similar feeding problems is a long process.

To the second session, the psychologist will invite another resident pediatric colleague who is part of the team, who has already consulted the dietitian colleague before the meeting and who will represent his/her views (see transdisciplinary teamwork). Since the medical tests ordered previously (physical examination, detailed laboratory tests, stool analysis, ultrasound) do not indicate an organic background (lesion, malabsorption, milk allergy, coeliac condition, etc.), the doctor focuses on the feeding-eating issue. Based on the food diary he or she will ask about all the meals of a typical day. The preliminary consultation with the dietician concluded that Zalán is not getting enough of all the nutrients. Most of the accepted foods are protein (formula), but many nutrients and vitamins are missing from the natural diet. Following a preliminary team meeting (with the team leader, the resident colleague, the dietician, and the psychologist), the resident doctor offers a calorie-rich, high-energy drink enriched with vitamins and trace elements, which she suggests the child drink in the evening, as this will help to make the nights more restful, while Zalán may still be hungry in the morning, which is important for teaching him effective eating behavior. He/she also recommends some syrups and drops to stimulate appetite. The team calls the parents' attention to the fact that the main goal is to establish a predictable daily eating rhythm and to help Zalán learn to recognize and satisfy hunger and fullness. Parents are reassured that the complementary foods offered and the vitamin supplements already taken are very important, so Zalán can slowly stop taking them parallel with the establishment of eating habits (the process corresponds to international guidelines, e.g. Chatoor, 2009). The doctor and the psychologist present the treatment plan together, also taking into account the parents' views. Behavioral support for eating will be provided by the psychologist, but the family will also meet with the doctors and the dietician from time to time during consultations. As the family lives far from Budapest, bi-weekly meetings are arranged in the mornings so that the father can still go to work afterwards.

During the rest of the consultation, the psychologist continues to lead the discussion while the resident colleague leaves and says goodbye to the family. In the parents' report, all three major symptom clusters of "infantile anorexia" are present as defined by the American diagnostic guidelines (Chatoor, 2009; DC:0-3R: ZERO TO THREE, 2005):

1) Zalán is an active, "constantly moving" child with a high level of nervous excitement;
2) There is a generational repetition: the father was a similar toddler, also living with eating difficulties; and even now, he follows a similar eating pattern (works all day in the carpentry workshop, often forgets to eat and drink, has a thin, lean build, and, he often eats properly only in the evening),
3) The generally observed autonomy-boundary-control problems also appear in the parent-child relationship, in discipline, in care situations and around mealtimes.

Education about important information is provided, and the psychologist, together with the parents, identifies that Zalán's story "fits" all aspects of this syndrome. This has a biological and a behavioral background, which is discussed in detail. Parents are given information that, in addition to medical monitoring, a behavioral intervention program can be effective, based on international experience (Chatoor, 2009). Parents remain motivated. It is agreed that consultations will take place in family sessions where the young boy and both parents will be present. They attend 8 sessions every two weeks, 90 minutes each time. At the last session, mutual feedback is given, and a decision is made as a team on how to proceed with the consultation and the frequency of the meetings. The goal agreed with the parents in the team is to improve feeding-eating behavior, so that the child starts gaining weight. To this end, as described above, before/alongside the start of behavioral and attachment-theory-based intervention, Zalán will be given complementary formula, the amount of which will be reduced in parallel with the regularization of feeding behavior. They also mention that the main aim of the intervention is the improvement of daily rhythm and eating, rethinking the way meals are taking place and the way conflicts arise (type and quantity of food offered, eating together at the table, etc.), but the psychologist indicates that all this will be discussed in more detail at the next session.

In the third session, the parents express their honest concern that some things (e.g. giving up “snacks” completely) will be difficult for them, because they feel sorry for Zalán and fear that he will stay hungry all the time and will develop even less. Nevertheless, after they receive sensitive support, educational discussion of the issues and the necessary interventions, they commit themselves to go ahead. Zalán is still actively playing, searching and finding, coming and going around the room, often contacting the psychologist, who responds kindly to his initiatives. Often the father plays with Zalán or runs after him so that he doesn't do something silly while the mother is talking. Zalán's speech has not yet started to really take on, as he mainly uses non-verbal communication to let his environment know what he wants. Speech development delays are also discussed, and the psychologist explains that active chewing helps to initiate articulation and productive speech, and that speech delays are a common co-occurring difficulty in feeding disorders. The psychologist recommends that after the age of two, it is also worth contacting the local early development center for help with this problem.

Parents report that, although they have some concerns, they have already made progress after the first two sessions:

- They stopped leaving around so many snacks, sweet tea, and juice in the house. They administer appetite stimulating drops. They feel that Zalán's appetite is better at 'proper' meals. Although Zalán has found the change difficult to accept, they mix the calorie-rich formula with his evening formula, which he now eats. He does indeed wake up less often at night, which surprises them. “Maybe that is when he was really hungry, poor thing,” says the mother.
- The parents have changed their eating arrangements, eating together more often (all main meals with mom, dinner with dad) from the same 'grown-up' plate, with Zalán helping to set the table, choose and prepare the food. He eats more from his own plate and sometimes asks for his parents' too. He seems to continue to eat well

at the nursery ("Maybe everyone eats together there, he sees the others," says the father). Lately, he has also accepted several new types of food.

- He has gained half a kilo in a month, which they are both very happy about. They are confident.

The psychologist confirms their efforts and common successes so far, and then goes through the Chatoor symptom list and other recommendations for improving feeding-eating in detail with the parents. Once again they agree that, beside taking into account and accepting Zalán's active, neurologically heightened, and always externally stimulus-oriented nature, the aim is to teach him to recognize the internal hunger-satiety cycle and to eat more food at regular, main meals, rather than continually taking small bites to satisfy his minimal hunger. This requires that they have regular, predictable mealtimes together, with flexible but predictable rules (e.g. sitting at the table and eating for a sufficient amount of time, 'food time' followed by play and all other activities). The mother expresses that she finds it hardest when she cannot give whatever and however much food she wants immediately, that she finds it hard to take 3-4 hour breaks, and that she is not always sure that she will be hungry when it is time for Zalán to eat. The psychologist confirms the possible solutions to avoid these problems that parents come up with, and also stresses the importance of a "contract" and constant conversation with the child about what, when and how they will do it and how Zalán can help. Since they measure the child's weight daily, the psychologist asks parents to weigh only every two weeks before coming for consultations, to which the mother adds with a smile, "yes, I know, so as not to get involved, like with tiny babies". The psychologist asks the parents to collect Zalán's favorite foods at home in collaboration with the child, as it is these foods that should be used to encourage sharing meals. They say goodbye with the father saying: "We need a solution to this constant misbehavior. Everything is the way he wants it". They leave the meeting with confidence, knowing that they will be able to talk about this at the next meeting.

Before the fourth appointment, the mother calls to say that she has an inflammation of varicose veins, can hardly walk, and has to lie down, so they cannot attend the consultation. The psychologist consults briefly on the phone and indicates that if they cannot attend the next few weeks because of her illness, they should definitely consult by phone about how they are doing and how the goals they have discussed are going. At the dietician's advice and request, the psychologist indicates to the mother (transdisciplinary knowledge) that the nutrient ratios in the diet should also be changed, as there is too much protein, too little carbohydrate and fat intake, and the child hardly eats any fruit and vegetables. Together, they collect foods from the list already requested that could meet this need, and which Zalán likes. The mother says that in the last few weeks they have been trying many of the things that were discussed in the consultations (longer intervals between meals, no snacks, no juice, formula during the day, mostly eating together, creative exploration of food instead of distracting games and TV, etc.). With a smile, the mother notes that "I can even put up with him messing around with the food he is served"). Some things work, some don't, but she says she knows it takes patience, and for them it is important that Zalán has put on another 300g. The psychologist confirms the mother that all this takes time. He/she asks the mother to ask the healthy father to visit her next time to report on the progress, even if the whole family cannot. The mother confirms that the father can come.

At *the fifth appointment,* only the father shows up, reports on developments at home: Zalán is slowly but steadily gaining weight, there are fewer fights over meals, but Zalán's "willfulness sometimes makes us fed up" says the father. The psychologist talks to the father not only about feeding, but also about cooperation in other situations and, in general, about setting up a framework to ensure a sense of security for young children, and about the possibilities and importance of setting boundaries (sensitive discipline). The father hands over a short list that the mother and Zalán made together of what Zalán likes to eat and what he "hates". There is also a small drawing on the paper that Zalán made: "cocoa roll". The psychologist asks the father to share what was said during the consultation with the mother.

Interruption of the process. Usually, families of children with infantile anorexia are looking into a long-term cooperation, because the symptoms are often resistant. The development of healthy and pleasurable eating behavior develops gradually due to the children's habitude and the deep lying beliefs and "eating scripts" of the parents. The intervention process cannot be expected to be completed until significant improvements in nutrient intake and weight gain are achieved. In our case, after the fifth session, the mother continued to suffer an inflammation of varicose veins for weeks and then had to undergo surgery necessitating several weeks of rest. In the psychologist's opinion at the time, the consultation should have taken place at least 5 or 6 more times, and regular medical check-ups should have been carried out after that. Other interventions planned during the psychological process included a video recording of the meals taken together, their analysis with the parents, the observation of feeding during the consultation, immediate reinforcing feedback, observation and discussion of interactions other than feeding, discussion of other problems brought by the parents (tensions in the family, disciplinary situations). The psychologist had a few more telephone consultations with the parents, who reported that Zalán had started to eat better and more predictably and experienced some gain weight (1.3 kg in 12 weeks since the first meeting). This was due to the syrups and drops and to doing some things "very differently". With the parents' permission, the specialists also visited the family pediatrician and the nurse, who confirmed that Zalán and his parents were "on track to gain weight". The hospital pediatrician and the district pediatrician agreed to monitor Zalán's progress more closely and to notify the parents immediately of the need for hospitalization if any further stagnation or weight loss was detected. The parents thanked the team for their work and said they would keep in touch with the pediatrician.

The team hypothesized about the sudden interruption of the process. Apparently, the mother's disease and surgery lasted for over a period of weeks, preventing them from coming to the hospital in Budapest from the countryside. They seemed highly motivated from the beginning of the process until the interruption. The external environmental stress may have been a distraction and it may have been difficult for the parents to fully appreciate that the insufficient weight gain had to be considered as a problem even when their child was active, vital, and cheerful. Since the father grew up with the same condition, it might have seemed less of a problem for them. Thirdly, parents tended to use medications, vitamins, other formulae, and age-inappropriate feeding (bottle feeding) rather than behavioral change. The change in food and introduction of appetite stimulating medication may have induced weight gain that the GP and parents were happy with. In the meantime, some behavioral changes had also begun, and the processes were sufficiently effective in the face of the stress associated with the mother's illness that the initial despair had disappeared. They felt more confident about the results achieved so far, which might have been a contributing reason for their suspending to attend consultations.

The case was taken to regular supervision by the psychologist. The factors that may have supported this parenting decision were gathered with the supervising psychologist, and the experience of temporary dissatisfaction and ineffectiveness in the psychologist was also addressed. The psychologist expressed concern, not necessarily trusting that long-term radical improvement would be achieved, as, according to literature, these cases can be managed or maintained through teamwork taking a long period of time. As the GP, in addition to the parents, confirmed that progress was taking the right direction, the parental decision had to be accepted. The collaborative work of the specialists and the GP and the trusting relationship between the family and the GP were the guarantee that with the knowledge, behavioral changes and supplementary nutrients, the child's development and growth would be satisfactory.

Lessons learnt from this case

In the field of pediatrics, in the ward and during outpatient care, interdisciplinary teamwork is the most effective way to address early childhood somatic and behavioral problems. The psychologist usually takes a role in assessing the psychosocial environment and behavior, and then becomes a key player in the treatment by supporting emotion regulation and behavior, parenting, parent-child relationship and family functioning.

4. DISCUSSION

Several theoretical and practical problems have been illustrated in the case study presented in this chapter. The result of paradigm shifts in medicine (i.e. the move away from the biomedical model) are also reflected in practice. Acceptance of the complex etiology of diseases and disorders, as well as systemic, family-centered and biopsychosocial thinking, are now essential in the identification of the causes of disease and in the planning of treatment in many fields including pediatrics. It is especially important in infancy and early childhood. The doctors involved in the case clearly adopted a psychosomatic approach, assuming body-mind-environment interactions in both directions: cause-effect and the repercussions of the problems on the individual mental state and the immediate environment.

Environmental stress as a central risk factor in the development and maintenance of disease was an important theme in our case. The question is: to what extent does a stressful life event contribute to processes in families living in already difficult circumstances? We can imagine the effects and development of stress in terms of a continuous two-way transactional interaction, as stress can cause or sustain illness over time, or the development of illness can increase the daily stress experienced, as the child's symptoms cause anxiety in the parents. This cycle can be acute or chronic.

In addition to the stress factors that are clearly risk factors, the availability and mobilization of peer support, the structure of the peer network and satisfaction with it are key to the protective process. In our case, we can highlight the role of the supportive family and the key people in the mesosystem, in this case the health care system.

The case also contributes to our understanding of models of illness experience and behavior, the doctor-psychologist-patient (child and family) relationship, and the development of compliance and adherence by parents in early childhood: in our case, the team had to formulate explanations and hypotheses for the sudden interruption of the process. In pediatrics, parents are the ones who decide on the treatment of the child, and their cooperation is therefore indispensable for the effective treatment of the child.

The environmental psychological and the doctor-patient relationship aspects of the hospital and the outpatient clinic as a setting strongly influence what the hours and days spent in the hospital or the clinic are like for a young child. Child- and family-friendly spaces and ways of working are essential for effective healthcare. There are large individual and age differences in how children think about and adapt to being in hospital. The importance of a supportive environment cannot be over-emphasized, but for children it is particularly important that parents/primary caregivers are a constant presence in the process. The younger the child, the more important this is.

Inter- and sometimes trans-disciplinary teamwork in care is now increasingly common in many areas of pediatric care in Hungary. The infrastructural and financial framework for the establishment of pediatric psychology is not yet in place, but international and national good practices are available to enable clinical health psychologists to become permanent team members in pediatric care in the near future.

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Part 3

WOMEN'S HEALTHCARE

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GYNECOLOGICAL PSYCHOLOGY

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1. INTRODUCTION

Psychological and psychiatric methods should also be applied in the field of obstetrics and gynecology, as these branches of medicine do not only deal with physical illnesses but also with natural processes (i.e., contraception, pregnancy, giving birth, and menopause) and the physical and mental changes that accompany them. However, these physiological processes may induce psychopathological phenomena such as anxiety or even depression. Emotional problems, self-esteem issues, and relationship conflicts may be underlying some gynecological diseases. According to psychological and psychiatric approaches, mental health disorders can often be linked to changes in the life cycle, which are much more prominent in women than in men. Hence, the psychological support of patients is essential regarding health prevention or recovery processes.

2. WORK OF A HEALTH PSYCHOLOGIST IN THE FIELD OF GYNECOLOGY

Diseases considered mainly having a psychosomatic background such as vaginal discharge, chronic pelvic pain, bleeding disorders, and reproductive disorders can clearly be linked to chronic stress, anxiety, and depression, in addition to socioeconomic status, lifestyle choices, predisposition to somatization, and psychological trauma (Szigeti et al., 2014). Health psychology in the field of gynecology focuses primarily on these phenomena. Tools applied include the establishment of a health-conscious attitude, the support of active health behavior, depression- and anxiety-reducing techniques, crisis intervention and trauma processing, grief counseling, and methods to process losses. Health psychological interventions in the field of gynecology can also aim to reduce anxiety associated with medical interventions, facilitate compliance and communication with medical staff, support decision making, promote self-functions, manage problems related to body and self-image, and support analgesia with psychological techniques (e.g., relaxation methods, suggestive communication techniques, etc).

Pelvic pain is one of the most common causes making women visit gynecological outpatient care. Pelvic pain is considered chronic if it lasts for more than six months. It may have an organic background with a gynecologic (e.g., endometriosis, adhesion, previous cesarean sections, pelvic congestion), gastrointestinal (e.g., irritable bowel syndrome), or urogenital origin. Some kind of a psychogenic origin can be assumed when no organic abnormality behind the symptoms can be detected, or pain persists despite the treatment of physical complaints. Chronic pelvic pain hinders activities of daily life. Moreover, the constant feeling of pain is often accompanied by frustration and irritability. It maybe helpful for the affected women to understand that the pain is not always the result of an organic disease but of a complex of physiological, socioeconomic, and psychological factors that vary individually. Treatment of chronic pelvic pain is a multidisciplinary task in which not only obstetrician-gynecologists and family doctors but also psychologists can have a serious role (Papp, 2006; Pál, 2019; Szigeti et al., 2014).

From an applied health psychological perspective, the primary aim of psychology in the obstetrical and gynecological field is to support healthy processes and prevention. Natural states such as pregnancy, giving birth, postnatal period, and changes in the life cycle may result in psychopathological processes, mood disorders, and anxiety symptoms caused by complex processes and causes. If there is an excessive physical and mental strain, exploring and treating psychological causal factors may be necessary. However, in general, the role of psychologists is to improve coping mechanisms, use stress management and health promotion techniques, and support solving the clients' social and communicational problems.

3. CASE REPORT: TO CONNECT AND BOND, THE CASE OF A 21-YEAR-OLD WOMAN

3.1. BACKGROUND INFORMATION, FAMILY RELATIONSHIPS, DESCRIPTION OF THE PROBLEM, AND THE SOURCE OF THE REFERRAL

Zsuzsi was a 21-year-old university student at the time who lived on a farm with her parents, older sister, and grandmother. His father worked as a primary producer. They kept animals around the house and farmed on a large land area. Zsuzsi loved the freedom that surrounded her in nature. She felt that her relationship with her father was poor and laden with conflicts, because he expected all family members to help tend to the farm. For Zsuzsi, this was a burden. She did not enjoy or want to help with farming, and this resulted in several conflicts and arguments with her father. She did not maintain a good relationship with other family members either. Her sister was 24 and was about to finish her university studies. Zsuzsi thought of her sister as a sloppy and lazy person. They shared a room where Zsuzsi was the one who kept things in order. Her sister regularly borrowed her clothes and accessories and used her cosmetics without permission. Her sister had a better relationship with their parents; therefore, in case of disagreements, they usually sided with her over Zsuzsi. They also gave more financial support to her sister. Zsuzsi had grown apart from her mother and grandmother; they had already stopped talking to each other. Her current partner, with whom she had been together for eighteen months, was currently the closest person to her. Her partner was younger than her. He was 18 and yet to graduate from high school. Since he was living in Sátoraljaújhely, he could only meet Zsuzsi biweekly at the weekends. They first met on an online gaming platform. The relationship was important for both of them; they planned to spend the upcoming years together. On those days when they were not able to meet in person, they maintained constant online connection and communicated through text. Usually, Zsuzsi traveled to her partner on weekends. Her partner's family accepted Zsuzsi, and she enjoyed spending her weekends there.

The attending physician (who also shared some initial information with me regarding the client) recommended the involvement of a psychologist in the treatment process. The young female client often presented complaints of recurring urinary tract infections to the family doctor, who gave her referrals to a gynecologist and urologist. Zsuzsi was free of complaints for a short period of time after the treatments; however, the recurring symptoms, medical examinations, and treatments were stressful to the patient on a psychological level. Thus, the attending physician recommended to involve a psychologist. The doctor asked the patient beforehand about this opportunity. Zsuzsi was open and accepting towards psychological support; she was particularly happy with the idea.

The constantly recurring health problems were hard for her to bear. She was worried and afraid that she *"could not get rid of"* these symptoms, which appeared first three to three and a half years ago when she was in 11th grade. It started with lower abdominal pain, frequent urge to urinate, and burning sensation when passing urine. She received antibiotic treatment with the diagnosis of bacterial bladder infection. Her symptoms resolved; however, she was later diagnosed to have a vaginal fungal infection. Following another treatment, she developed vaginal tears. The causes behind her complaints of urinary tract symptoms and constant feeling of discomfort were sometimes shown to be of urological origin and other times a gynecological background was proven. By the time one symptom got treated or managed, another emerged. She was in her first relationship at the time when her symptoms first developed. This was also the time when she had had her first sexual experience. Looking back, she evaluated her past relationship negatively. She and her ex-partner had broken up a couple of times and then got back together throughout the span of the relationship of two years. Her ex-partner had cheated on her multiple times. In retrospect, she believed that her first boyfriend humiliated her and did not respect her at all. She became aware in the meantime that sexually transmitted diseases might also cause urinary tract infection-like symptoms. She postulated that she got an infection while having intercourse with her first boyfriend, who often changed his sexual partners throughout their relationship. Since then, she paid more attention to prevention, but regardless, her complaints reappeared from time to time. Her current partner accompanied her to visit the attending physician and got treated as well; however, it did not solve the problem. Zsuzsi's symptoms and illnesses negatively impacted the relationship as they narrowed the opportunities for sexual activity, which was already limited by the physical distance and rare personal encounters. She said that although her partner is understanding, patient, and accepting; still, she sensed some tension.

Along with her health complaints, she also mentioned some additional difficulties and problems stemming from her current situation. She was distrubed as she percieved her life as meaningless and was unsure about what to do with herself. At the time of our work together, she studied business informatics (the subject her sister also studied), but Zsuzsi did not enjoy studying; this major did not motivate her. She started her studies at a university away from home and lived in a dormitory. She really enjoyed being finally able to have some distance from her sister and parents while studying there. She formed new relationships and enjoyed being a university student. However, already at that time, she felt unmotivated to study and failed some of her exams despite her previous love to study let alone the fact that she graduated from high school with honors. Later, her family could not keep up financially supporting her studies and living in the city, so she moved back home and switched universities to one which was closer to her home. She did not make any friends there. Zsuzsi started a student job to accumulate some savings that she now used to pay for her medical examinations and treatments and pay the travel costs of visiting her boyfriend.

Regarding her family life, she wished to finally have her own room until she could move out and be alone. To be able to move out, she needed to have her own income; however, she could only start a proper job after getting a bachelor's degree. Due to the failed exams and missing credits, she took a year off. There were one and a half years still remaining till graduation. Zsuzsi also hoped that her sister would move out as she would find a job after graduation.

3.2. THE CONSULTATION PROCESS, THERAPEUTIC FRAMES, AND INTERVENTIONS

The client initiated the first contact via phone. After fixing an appointment, the first session happened at the Psychology Ambulance of the Department of Obstetrics and Gynecology when Zsuzsi came to the clinic for a follow-up examination. I met a young, thin, reticent, soft-spoken girl. Her appearance was like that of a young girl; she did look younger than her age because of the way she dressed. Her naturally red wavy hair and freckled face also made her seem younger. At the first session, I explored her family background, current health status, and past medical history. Furthermore, I inquired about her current life situation, circumstances, social relations, and pastimes. Taking down the medical history continued during the second session. I aimed to investigate the psychological resources in Zsuzsi's personality, relationships, and her way of functioning. I also examined her motivational background and stress management skills. In this session, we focused on her current and previous (and at the same time, her first) relationships. We touched the subjects of relationship satisfaction, sexuality, body and self-image, and femininity. During the first two supportive therapy sessions, I tried to position the appearance of the symptoms in the client's life story and explore those life events that could be associated with these complaints. I tried to identify potential links between symptom progression, the subjective experience of illness, the major events of her life story, and the changes in her interpersonal relationships.

According to the framework of gynecological psychosomatics, unresolved conflicts (such as loneliness, isolation, relationship conflicts, and challenges at work) may cause physical symptoms and underlie chronic pelvic pain and psychogenic vaginal fluor (i.e., vaginal discharge). In case of unfulfilled sexual desires or sexual repressions of a psychogenic origin, these symptoms may also serve as protective symptoms keeping the client away from sexual intercourse or the partner. Neurovegetative instability and non-specific stress situations may also underlie these symptoms. They may also be associated with other psychosomatic symptoms, such as chronic pelvic pain. Chronic recurrent syndromes can also develop along a leading symptom of pelvic pain, accompanied by sexual disorders, digestive disorders, headaches, and bleeding disorders. This state is often associated with the sensation of helplessness and powerlessness. Healing work can be aided by information regarding the patients' life story, expectations, desires, fears, family and work environment, and relationships (Pál, 2019).

Following the first consultation with the client, we agreed on a contract for four additional sessions (five altogether) held weekly. The first interview made it clear that the client's difficulties included her perception of her life as stuck in her current situation, pointlessness, and lack of motivation. Furthermore, other issues were also present such as her frustration due to her illness and disappointment, which negatively impacted her self-image and experience of her femininity, and influenced her relationship with her boyfriend and family. Therefore, the aim of the psychological support was self-reinforcement, the promotion of self-functions, and the improvement of self-knowledge and self-esteem. The consultations occurred on an outpatient basis at the Ambulance for Psychology. In between sessions, I discussed the case with the attending physician and gave them feedback. Following the first session, her attending physician presented the past medical history and treatments of the client while I informed them of the potential parallels between life events and the appearance or exacerbation of her complaints. Later, during the psychological intervention, I inquired about the health status and symptom changes of the client, and after the termination of the therapy, we had one more consultation about the improvements of her state.

By the third session, I experienced positive changes in Zsuzsi's emotional state and mood. She told me that her gynecological complaints had lessened and that she spent the weekend with her boyfriend. Her mood improved, and she felt better. Because of it, she noticed that she was studying harder for her university classes. As a result of the last two consultations, she made several observations for which she expressed being thankful to me. Her need for a more conscious self-knowledge increased. She attended a lecture that focused on self-knowledge, subjective well-being, and relationships. Moreover, she also started to read a book on self-knowledge. Zsuzsi said that she could never really accept herself, her appearance, and body, but she only became aware of all this at our sessions, via the lecture, and reading the book. She believed that her negative feelings toward herself were connected to her illness. She wanted to understand the associations between her feelings, thought, difficulties, and physical symptoms, which increased her motivation to understand herself and engage in self-knowledge more deeply. She realized that she usually saw herself and the things that happened to her in black and white, and that she had a predominantly pessimistic attitude which stopped her from recognizing when good things happened to her. In light of these realizations, she re-evaluated her relationship and started to value more the attentiveness, patience, and care of her partner, something that she had not received from her ex-partner. Altogether she started to appreciate having a partner and not being alone. She also shared with me that she assumed a strong link between her lower mood, symptoms (and the pain), relationship difficulties, and aimlessness (lack of motivation); she felt these factors were strongly linked.

Following our third session, I presented the case of Zsuzsi at group supervision. I decided to present this case because the counseling process seemed to go too fast, and the client reported great changes within a very short period of time. These changes also manifested in her appearance; moreover, Zsuzsi became more open in her behavior. She made the impression of a more self-confident and determined young woman as compared to how she appeared at our first encounter. These changes made me feel more uncertain and cautious. *Is it possible to achieve such a great change in such a short time period? How long would a change last that had come so fast?* The group case discussion helped me to find answers to these questions: Zsuzsi's feeling of liberation might stem from her experience of pain mitigation and the novelty of having a psychologist. After all, this was Zsuzsi's first time at a psychologist where she could release her tension and talk about her burdens and difficulties. As she did not have friends and could not share her problems with her sister and mother, this was all new to her. Prior to that, the doctor's office was one of the places where she could experience that someone listened to her and paid attention to her when she talked about her problems or physical symptoms. This attention might unconsciously maintain her symptoms. However, she now could understand that being more conscious in certain aspects helped her and gave her a new direction. Furthermore, Zsuzsi also received a novel experience regarding ways of communication. She usually communicated online through text during gaming, while 'talking' to other gamers (who were mostly strangers to her). When she was at the psychologist, communication turned into a "here and now" experience with immediate reactions and spoken feedback.

In the fourth session, I gave Zsuzsi feedback of my feelings and impressions regarding her change that I also discussed in the supervision group. I consciously tried to also express my positive thoughts and feelings. For example, I praised her boldness for opening up and changing her life, and I tried to increase her self-confidence through affirmation, supportive talk, and honesty. Then, I asked her about her feelings regarding our work together. She said she was grateful for the opportunity. It was new and surprising even to her that her attitude changed so much and how she now had a different view of herself and her relationships. She wanted to learn more about her functioning and needs. I tried to emphasize that she could gain more knowledge of herself and her behavior if she participated in interactions, since social interactions help us learn about ourselves. Moreover, she could experience again sharing her thoughts and experiences through these relationships. During this session, I offered her an opportunity to choose the topic of the last (termination) session. I had a feeling that having an opportunity to decide within the counseling process would be important to her for having a sense of control, as she had a problem with regulating how her body functioned.

As a result, during the fifth session, we went on to work on her self-knowledge and self-image, which was followed by the termination of the counseling. I offered her to work with a symbol by analogy to her seeking herself and her self-boundaries. The symbol was the image of her own room. She repeatedly mentioned that she was longing for her own room, which would only belong to her. A room that she could form and shape as she preferred. I asked her to imagine that she had her own room. How would this room be? What would be where? How would she furnish it? During my work, I often employ meditative-imaginative methods. In symboltherapy, the use of basic symbols such as the house or room can be used to walk through internal routes and for exploratory work of self-knowledge. The processing of the experiences aids psychological and self-exploration and leads to unfolding the links between the outer and inner world. The therapeutic work with inner images can result in internal changes that are detectable from the outside through behavioral changes.

After the imagination practice, we evaluated and terminated the counseling process.

3.3. MOTIVATION, COPING SKILLS, RESOURCES, AND GOALS

Zsuzsi had a motivated attitude and an accepting behavior regarding our work together from the start of the counseling. She was deeply immersed in the topic of relationships and self-knowledge; moreover, she indicated a need to improve her self-knowledge to support her career choices as well. She was initially demotivated regarding her university studies. Her primary motivation for the counseling was to alleviate her physical symptoms; the goal was to cease her complaints. We tried to set the goals as precisely as possible during the first session: instead of focusing on the lack of something, to achieve a desired state (to which we could pair her efforts and commitments). She also reported motivation concerning developing her self-efficacy and self-knowledge to improve her relationship with her family, which she perceived to be laden with conflicts. Her relationship with her boyfriend was a resource from where she could gain experience of acceptance and understanding. She also talked about the lack of social support. She did not have friendships, only acquaintances with whom she communicated during online gaming. Her coping strategies were rather impulsive and emotion-driven; thus, we attempted to develop more adaptive ones.

3.4. CHANGES EXPERIENCED THROUGHOUT THE CONSULTATION PROCESS

Zsuzsi's physical and health condition was characterized by short asymptomatic periods followed by relapses. She demonstrated positive changes in her behavior during the course of psychological aid, especially when interpersonal communication appeared, i.e., when she experienced the psychological intervention in real space. Throughout the counseling, she could experience the liberating feeling of communication and sharing. She reported the mitigation of her recurring complaints, which lasted even after the termination of the counseling.

Lessons learnt from this case

I experienced the case reported here in the first year of my work in clinical health psychology. The complaints and accompanying psychological factors presented here are quite common in my field of psychology, hence the decision. In addition, my aim was to present a case that I encountered as an early career psychologist with only a few years of experience, so students pursuing psychology residency and MA students specializing in the clinical application of health psychology also find the case report helpful. This case demonstrates for me that there is a strong link between the function of the body and mind. It taught me how to explore the underlying causes behind the easily observable and visible complaints. I also learned that embracing the mental state is of utmost importance in mitigating the physical symptoms. Furthermore, the collaboration of medical doctors and psychologists, as well as the joint management of the patients are essential for an effective treatment.

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PERINATAL MOOD DISORDERS – AN APPLIED PERSPECTIVE

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1. INTRODUCTION

In the life of a woman, pregnancy is a period with the prospect of self-fulfillment; however, it also involves numerous emotional, mental, physical and social changes. Becoming a mother and starting a family often evokes unexpected psychological strains that are difficult to cope with. Pregnancy – either planned or not – exerts psychological effects on women that are difficult to handle. That is why pregnancy is considered a state of crisis; from the onset of planning a family throughout all the three trimesters of a pregnancy, various emotional factors occur that might provoke anxiety, depression or, though rarely, even psychosis/psychotic episodes in the clinical sense (Belső, 2006b). In addition, pregnancy also affects the quality of the relationship of a couple and other social relations. As pregnancy might produce symptoms that require full attention and, if necessary, appropriate attendance, pregnant women need the devoted attention and support of their health care professionals. Untreated psychological symptoms may damage the fetus, but also exert an adverse effect throughout all the stages of motherhood, and thus harm the baby's development and may even destroy the couple's relationship. Proper psychological support is therefore vital for the family to function better and support couples in their decision to become parents.

As early as at the stage of planning a family, hurdles can occur resulting from inadequate mental processing of a miscarriage or a failed conception. In the first trimester, even in the case of planned pregnancies, malaise, fatigue, fear of miscarriage might cause anhedonia-provoking symptoms. The second trimester is usually a more peaceful period provided that the first genetic screening tests yield ideal results. Somewhere between the 12th and 24th weeks of gestation, mothers start feeling fetal movements, that is, the existence of the child becomes palpable, more realistic, while the size of the abdomen is not as large yet as to impede the mother in everyday activities. In contrast, the third trimester is strenuous again with the date of delivery approaching, movements becoming more and more difficult and fears and worries may appear relating to giving birth and caring for the baby. In addition, financial and existential questions might emerge further intensifying tension that the couples feel (Martini et al., 2016). These may even reach the extent of pathological anxiety or depression that call for help by a psychologist (Barker, 1995). These could be day-to-day life experiences, such as disruptions in everyday routine, experiencing stubbornness due to maximalism or perfectionism, concerns regarding proper nurturing of the infant or even the difficulties of mother-infant attachment after birth. These are completely new feelings and in case they are not dealt with and processed adequately, they can even lead to pathological anxiety or depression.

Initially, depression studies were limited to the postpartum period. We distinguish three types of depression: (1) postpartum blues, which occurs in the days after delivery and lasts for about ten days, with a prevalence of 50 to 80%. Postpartum depression develops in the cases of prolonged maternity blues and affects 15% to 25% of mothers, while postpartum psychosis occurs only one to two mothers per one thousand deliveries, and starts mostly in the first postpartum week. (Beck, 2006; Doucet et al., 2011; Henshaw, 2003; Kennerley & Gath, 1989; Pitt, 1973; Ross et al., 2005).

The incidence of either minor or major forms of depression in different trimesters during pregnancy shows different patterns. Gaynes and colleagues (2005) in their meta-analytic study found a pathological rate of 11% in the first trimester, 8,5% in the second, and 9,7% in the third trimester.

Extensive research has investigated whether untreated maternal depression can cause complications that may pose a risk to the fetus and the mother during pregnancy. Untreated depression during pregnancy often leads to opting for epidural analgesia during labor, that is, endurance of the perceived pain might depend on the mental state of the pregnant or the degree of psychological readiness for the delivery (Chung et al., 2001). Untreated prenatal depression is also more common in the cases of caesarean section or even preeclamptic symptoms (Cripe et al., 2011).

According to research, depression during pregnancy also affects fetal development: it can lead to premature delivery (Jesse et al., 2003), intrauterine fetal retardation (Qiao et al., 2012) or low birth weight (Hompoth et al., 2017; Rahman et al., 2007). In the postpartum period, a depressed mother is less able to attach to her child (Righetti-Veltema et al., 2002), performs less verbal interactions and smiles less at her baby. Furthermore, depressed mothers have more difficulties breastfeeding their babies, and this also adversely affects their sleep (Field, 2010).

All the abovementioned studies clearly demonstrate the severity of mother and fetus complications that perinatal depression can induce. Therefore, it is of utmost importance to view pregnancy from a mental health approach and consider expectant mothers' psychological care as crucial for prevention.

2. Case Report

In this chapter we present a fictional case. We have decided on this option because the period examined is quite long: pregnancy itself lasts for 9 months (its different stages evoke different types of problems), the postpartum period lasts one year after delivery, but patients often seek psychological support in obstetrics departments with pre-pregnancy difficulties as well. For instance, they often need counseling in the cases of problems with conceiving, fear of infertility or coping with a prior perinatal loss. We dealt with clients mostly on a short-term basis focusing on the main problems they brought in. However, our aim is to demonstrate the broad variety of difficulties this period entails, thus we created a fictional client character exhibiting the most common problems (and named her Ann). Texts in italics indicate typical patient language use, and words in quotation marks are quotations from sentences uttered.

Ann is a thirty-five-year-old intellectual. She arrived in an elegant dress and impressed with a tidy look. A kind of fatigue was visible in her posture, yet we could also feel that she still had strength and resources. She told us about a complex problem: she and her husband had been trying to have a child for years. After a year of attempts, they underwent medical examinations and, as a result, they tried timed intercourse. Ann felt that this had a negative effect on their relationship and was afraid of losing intimacy. In addition, she also developed hypochondria due to the several medical visits and *her inability to live up to the evolutionary call.* She feared that she was soon to receive a diagnosis of infertility, so she developed anticipatory grief. She had feelings of guilt and anxiety and wished *she hadn't focused so much on her career and hadn't waited so long, she was afraid that she was too late and she wouldn't be able to become a mother anymore.* We worked on these difficult emotions in a couple of sessions. As a result, she and her husband started spending more quality time together, talked about their fears and were consciously trying to make their sexual intercourses more intimate (despite having it pre-determined). We were also talking about the various psychological reasons contributing to successful conceptions: we explored stressful situations in her life and identified possible coping strategies for her, such as relaxation, stress relief through workouts, communication techniques and improving her ability to say no.

During our work together, she managed to become pregnant; however, her happiness was interspersed with concerns regarding the possibility of an illness and the loss of the fetus. An intense anxiety and fear developed, as *at her age, there is a higher probability of its occurrence*, and *what will happen if they have to start the whole procedure all over again or if she needs treatments again and they will have to miss out on spontaneous intercourses.* These fears overshadowed her joy of being pregnant; she was not able to enjoy her pregnancy. She mentioned further problems, such as being nauseous, depressed, tired and experiencing cognitive dysfunctions. I tried to help her look at these symptoms from a different perspective: they might stem from the hormonal changes of her body as it was preparing to feed and nurture the fetus, which is a highly strenuous process involving a lot of change, therefore her fatigue, cognitive problems and depressed mood were all explicable. Nausea was also logical as her body tried to protect the fetus and that is why she was much more sensitive to odors, so that she could better filter out potential sources of danger that her body signaled to her that way.

Another source of her anxiety was the genetic screening due at 12th weeks of pregnancy. Ann began to worry again that the screening might detect some fetal anomalies that would lead to the loss of the fetus, and, subsequently, to the necessity of starting the demanding process of conception all over. She dreaded the possibility of her fetus having Down Syndrome, because, in this case, she would have to make a decision about whether to choose an abortion or raise a sick child. *'I am terribly ashamed of it, but I have always been scared of people with Down syndrome. I don't know why, as I've never had any bad experiences with them, actually had no experiences with them at all... but the thought of having a sick child scares me.'* During our conversation, it turned out that she had always been afraid of new, unfamiliar things but when she had had the chance to get involved in them, her negative feelings disappeared. She was therefore pondering to volunteer with self-help groups of people affected by Down syndrome, as she thought that way she would have the opportunity to get to know them better, and it could help alleviate her anxiety. I also asked her what would help her reduce her fears of possible other illnesses. She responded that *more specific knowledge about, for example, prevalence rate, consequences and possible solutions.* Therefore, we went on to deal with her relationship with her health care professionals and I advised her to talk to her gynecologist about her concerns as she could receive a lot of information from her doctor. During the following sessions, she was much more relaxed and talked enthusiastically about how she asked her gynecologist to reassure herself. She found it useful as it helped her build trust in him and from that time on, she felt that she could count on him much more than she had previously expected. She also mentioned that talking to her doctor also helped her reduce concerns regarding delivery and that she felt *she would be in safe hands when the time comes.*

In the second trimester, her feelings of discomfort, cognitive impairment and fatigue all decreased. Her relationship with her husband improved and *everything started working out fine between them again,* though certainly, they still had some disagreements and debates over their plans. Although they were able to agree on many issues, Ann felt that sometimes they were not really listening to each other and she could not make her husband understand her feelings; sometimes tension between them increased up to a point when one of them eventually offended the other. We started talking about Ann's problem solution techniques with regard to assertive communication. We found out that her husband might have felt being attacked and accused so his motives were not to 'attack' Ann (as she first put it) but to defend himself and fight back. At first, she listened skeptically and felt that the method was hair-splitting as the point remained the same. However, she slowly began to see the difference and became enthusiastic: she wanted to practice being assertive and role-play situations, as she was eager to apply it properly to her life. She also thought she could teach it to her husband in order to improve their communication. During the following sessions, she pointed out that they were having successful conversations, or, in those when they failed, she asked me how they should have behaved differently or what expressions would have been more appropriate.

She had some other concerns. First, about her fetus: she could not sense its movements yet, and *her mother said that at that period Ann had already been moving in her womb*. In addition, the approaching date of the genetic test due at week 20 further intensified her anxiety. She assured me that she was going to ask her gynecologist for information about both issues, just as she had done before, but *at that moment she felt her concerns were overwhelming her.* It was possible to alleviate her anxiety with simple statements such as: during the first pregnancy fetal movement only becomes perceptible at a later stage; and every fetus is different, some move less in a given period so it does not necessarily indicate abnormal development. Regarding the genetic screening outcome, she felt it useful to voice her fears without the presence of her spouse who often ignored the topic with phrases (although probably out of a desire to help) like 'oh, don't even bother with it', 'come on, everything's gonna be fine', 'you shouldn't even think about it' 'you're thinking too much about it' and so on. She said she often came across similar reactions when she wanted to talk to her friends, so she always felt that others were closing in, avoiding the topic; no one wanted to listen to her. In our sessions, she had the opportunity to express her thoughts and voice her fears to somebody listening attentively, not avoiding the topic and not interrupting her. She felt it liberating.

During the following weeks, she began to feel fetal movements and the genetic screening was over, so she was much more relaxed. She expressed her relief in several ways: *how much her burdens were eased and she was ready to let herself get emotionally involved in her pregnancy. Up to that point, she hadn't even dared to get too close to her fetus as she was constantly afraid of losing it; she was convinced that something bad would happen. She was still aware that unexpected difficulties might occur any time, but still she started to let the joy sneak in her heart. She 'allowed herself' to caress her belly, immerse in it, and she began to talk to the fetus, about the plans they were making with her husband.* She was even more relieved and happy after the 24th week, the age of viability, i.e. from this time on the fetus is more likely to survive in the event of a preterm birth. On the other hand, her abdominal circumference began to increase noticeably, so it began to become uncomfortable to move and sleep, and her stamina and performance decreased. It wore on her, as she had felt stressed and tired enough before, and her problems with sleeping made it even worse. The situation has improved somewhat when she implemented relaxation exercises in her daily routine and allowed herself to rest and recharge during the day when she felt it necessary. Also, she bought body pillows to support her body during sleep. She was worried because she often felt short of breath which she had not experienced before due to her regular workout in the past years. Consequently, she felt as if her hard workouts had been in vain. I assured her that it was usual and typical; the growing fetus occupied more and more space in the uterus, thus it compressed her organs and lungs a little.

At around week 30, her worries took a new direction: first, she was troubled by the thought of delivery; secondly, she had doubts whether she was going to be a good mother, *be able to do it well.* We began with exploring the background for her fear of delivery. She was surprised to realize that she merely had some quite general and superficial theoretical knowledge about it. She became interested and began reading a lot on the subject, talked over the details with her gynecologist, and during our sessions, we focused on its mental aspects. One of the topics that she became preoccupied with was the altered state of consciousness during labor and delivery. She imagined it as a situation completely out of her control and that frightened her. We clarified that a narrowed attentional focus is typical when delivering, as it is a difficult and serious challenge that requires full attention. However, she did not need to be afraid since she would be surrounded by her gynecologist, her spouse and the midwife to help her 'maintain control' over factors she would not (or not continuously) be able to pay attention to. I encouraged her to make plans with her husband about what they assumed she would need, what are the tools that might be of help during labor (gymnastic wall bar, gymnastic ball, etc.) and ask her gynecologist which of these were available at the hospital they had chosen, what postures are recommended at childbirth and in case of a caesarean section how she could have some influence on it (for example if she wanted her husband to be present), and so on. Unexpected situations can definitely occur any time, but the more scenarios she was prepared for, the more secure she would feel. Her husband could also be of help if her narrowed focus hindered her to be able to pay proper attention to her environment (questions, information) and she might happen to have difficulties with decision taking. Should it happen, her husband might function as a so-called 'assistant self', that is, he could help her due to his knowledge about their relationship and the pre-agreed plans, for instance, he could paraphrase a question (to make it more clear) or can take certain decisions. I also recommended her to talk to her friends who had already undergone giving birth as she could gain new ideas, aspects and topics that might as well be beneficial. She could even search for videos about delivery if she thought it would help her gain indirect experience about the process. After all, she decided not to watch these videos though she had searched for them as she did not have the courage to watch them thinking it would only scare her off even more. We certainly acknowledged her decision since we always look for the things that can help our clients.

She also had concerns about the pain and the treatment options. She admitted that she could not bear the pain in general, it made her frustrated and she was afraid of it. She was afraid that she would not be able to control it; *it would absorb and 'devour' her mind.* She had already talked to her gynecologist about pain-relieving options which partially calmed her down. In addition, she attended prenatal classes where she learnt specific breathing techniques. During several sessions, we focused on the topic of pain: what it meant to her and how she could cope with it. *'Whenever I feel pain, I think I am going to lose control, my body betrays me, it takes over control, I adjust everything to it, it rules me.'* We emphasized that pain is there to indicate physical problems so her body does not destroy her; on the contrary, it helps her survive, and takes over control to lead her towards specific activities and make her avoid other activities that would harm her in order to prevent possible injuries, alleviate the pain and help her recover. However, I framed it as natural to perceive it as a difficult situation since deep, instinctive mechanisms come to rule and suppress her conscious self but she must be aware that they were in the same boat, just like teammates fighting for the same goal. During delivery, pain indicates contractions to prepare her body for another push. She seemed to understand this approach and, at her request, we formulated positive autosuggestion affirmations that would help her during delivery. For instance, '*Pain is manageable and it helps in childbirth* ', '*we work together with Janka (her child's chosen name) to help her birth*', '*I trust my doctor, the staff, I am safe* '. We also elaborated on the topic of altered state of consciousness that heightens the level of susceptibility so we also created phrases of affirmation that her husband would use to help Ann during childbirth. After giving birth, Ann told us that during delivery, she remembered barely anything of the phrases we constructed, but when she did, they seemed to help her, and throughout labor, she felt much calmer when she thought of her mantras. Besides, her husband's support helped a lot and her husband felt more confident due to the prearranged phrases and tasks that provided him solid ground to rely on.

In this period, she was looking back on her childhood, scrutinizing her relationship with her mother. She had various memories: pleasant, sad, infuriating. However, she started to look at them from a different, distanced perspective: 'I agree with that', 'I would never do that', 'I still don't understand why she took that decision then'. Meanwhile, she was wondering a lot about the questions 'Am I going to be a good mother?' 'Can I change my parents' bad patterns?' 'Will I be able to do it differently from what I learnt in my childhood?' 'What if I'm not better than them?' 'Will I destroy my child's life with my mistakes?' These are serious problems that concern many people. Therefore, we talked about what 'being a good mother' meant to her, what are the characteristics, behavior, external and internal qualities that she considered important. How does 'a good mother' lead her life? Does she sacrifice everything or does she allow herself to self-care as well? Is it selfish to want some me-time? Can she ask for help or accept it? She was puzzled, as she had seen only extreme cases of motherhood both in movies and in her own life: she had a polarized image of moms either being '*supermoms*' or '*failed moms*'. In her view, supermoms control everything perfectly, beside housekeeping (and work) they still have time for keeping fit, taking their children to various activities, volunteering for school projects, baking cakes for neighborhood parties, etc., and they do all these without complaints. In contrast, we always see the 'failed' mom in her worst moments, for example, when she happens to be worn out, she is quarrelling with her spoiled, peevish kids, or when they are looking helplessly at their toddler throwing a tantrum over chocolate. *We tend to feel sorry for them, or even voice our opinion about them being such failures as parents. I am terrified of experiencing such humiliation one day. … In the movies, this is the 'need-to-be-rescued' type, which is also a worrying thought for her as she preferred solving problems herself rather than 'being saved'.* As a result of our conversation, her image of being a mother became closer to reality and she was able to relate to herself and her role as a mother more effectively. We also talked a lot about the necessity to be open and flexible, and that she needed to re-evaluate many things. Subsequently, some of her standards and values changed and she wanted to follow the new principles. She also told us how preoccupied she was with her childhood sorrows and that she tried to convey her feelings assertively towards her mother. Their conversations resulted in debates, but in the end they could accept each other's points of view (as for Ann, she could understand that at that time her mother had found the solution she had chosen to be the best; and as for her mother, she realized that she had hurt her daughter's feelings, even if not deliberately). Thus, they got closer to each other and some of their wounds began to heal.

We met a few days after her delivery, without a scheduled appointment. She was still in her ward and requested my visit because she evaluated her symptoms as depression, which made her truly scared. She reported on her delivery experience as well: it had started suddenly so the ambulance had taken her to the closest hospital and not to the pre-chosen one. She had been unprepared for that scenario – although its possibility had had crossed her mind briefly, but it had seemed very unlikely, therefore she had not made a plan for it in detail. The most shocking and terrifying thing about the new scenario was that she had to rely on another, unknown gynecologist. She recounted in tears how terrified she had been. Finally, owing to staff kindness and her husband's encouragement, she had managed to calm down and fortunately, delivery had taken place without complication. However, the experience left a mark on her. She was sure that her depression and symptoms stemmed from that. She complained about mood swings, being oversensitive, feeling like crying all the time, being extremely tired but having trouble sleeping well and waking up to every little noise. Although earlier we had discussed the effects of hormonal changes after childbirth, she was afraid that her symptoms indicated a greater problem. Talking it over again helped her ease off and her body posture got visibly more relaxed. In the following two weeks, she planned to stay at home with her husband and her newborn, so we scheduled our session only after that period. Nevertheless, we agreed that she should call me to meet earlier in case anything unpetted her.

After the two-week break, she returned a bit exhausted. She was still having sleep problems: she woke up to little noises during the night and many times to breastfeed her child. She tried to make up for the lack of sleep during the day but she said '*I keep waking up all the time to Janka's crying'. I'm terribly ashamed but the question 'why on earth is she always crying?' has run through my mind several times. But when she isn't crying, then that bothers me and I worry about what might be happening to her, why she isn't signaling at the usual time. Nothing is good... whatever happens I find something to worry about'.* We talked in detail about the fact that each baby is different, has different needs, moreover, their needs also change over time and sometimes there might be swings in, for example, her sleep cycle, appetite, weight gain and so on. I suggested her to consult a health care professional regarding her concerns, but I also pointed out to her that she should always be aware that infants are not like clockwork and she should trust herself more.

At this point she started crying: *'Well, that's it!' I can't rely on my gut feelings! They aren't telling me anything! I've got no idea why she is crying, I don't understand, I don't know what she wants! I don't know whether she is hungry or is having a stomach-ache, or what other problem she's having... I'm a terrible mother, I don't understand my own child... and ... and ... I don't feel anything for her... I can't love my own daughter... What kind of mother doesn't like her own child?!'* She was extremely upset. I let her cry for a while, quietly encouraging that she could ease the tension there, she was in a safe space and after that we would discuss everything. A few minutes later, she apologized saying that she had just realized how miserable she felt and that surprised even herself. Although these thoughts had already crossed her mind before, she had not cried over them yet, she had always brushed them off and concentrated on her daily tasks instead. We were having a long talk over the fact that at that moment they were experiencing a brand new situation which demanded brand new knowledge and rules without having handy, ready-made patterns to follow; and learning from one's own experiences always requires time. They also needed more time to get to understand Janka's infant communication as it was completely different from ordinary communication so they needed to get used to it. I assured Ann that she would systematically become more and more confident in recognizing the differences in the baby's signals, figuring out her needs and the ways to fulfil them. I also told her that love needs time to develop, it does not happen the way we see it in the movies. She needed to understand that her newborn was evidently a bit of a stranger to her and she was just getting to know her. Obviously, some kind of a relationship had already been formed between the two of them while her baby had been developing in her womb, but it was a completely different situation. When she was born, everything changed. Until that time, she had only been a product of her imagination, but now she was a living human being with feelings, experiencing and reacting to the outside world. I told her to think of a situation when we meet a stranger: we can have an image of them based on stories we have heard about them, our first impression might be a good one, yet we need time to get to know and like them and we need even more time to get to love them. I encouraged her that love towards her child would obviously develop much faster as they were spending all the time together, but I also reminded her that the situation was somewhat similar. *She felt an immense relief when she realized that it was not her inability to be a good mother that generated the whole issue, as she had the distressing idea that her conception problems arose from her incompetence for motherhood.*

She had insufficient breast milk supply so she had to buy infant formula to feed the baby, which also provoked guilt and shame as she felt *she wasn't able to nourish her child, her body wasn't giving enough from itself to her baby.* In order to reframe her perspective, I explained that her body was not selfish; it just tried to maintain a healthy balance. She was suffering from lack of sleep but, at the same time, she was overwhelmed by her constant worries and by trying to control and manage everything properly. All these were soaking up all her energy. Yet, from the little energy she retained, her body was striving to produce food for Janka. I advised her to be more patient and empathetic with herself and create some me-time to re-fill her energy. I recommended her to ask the grandparents to help with Janka, for instance while she was having a walk, the grandparents could be happy to take care of the baby.

She also mentioned how hard she found it to put up with the mess in the house. Beforehand, she had always been able to manage household chores and keep the house clean and tidy. This had changed, and she was frustrated because house-related responsibilities had become a never-ending task: as soon as she finished one of them, she had to start doing another. *She felt everything turned into chaos, she was going under, she felt excessively overwhelmed as she was not able to do the cleaning at such a pace.* We spoke about how a baby's arrival can turn one's life upside down. In most cases, the changed circumstances and priorities required a total re-organization of daily activities. I advised her not to compare it to her previous lifestyle; rather, she should re-structure her daily routine and create a new system that would tolerate a sink full of dirty dishes – a typical consequence of trying to attend to a baby's needs. As long as she had some clean dishes to use (or she can quickly clean some), there was nothing to worry about, she should be more at ease with herself, as washing the dishes was a much less important a priority than the baby's needs, therefore it was natural of her to ignore them. I also pointed out the possibility of asking the grandparents to help her out for a few hours per week, or to hire a house-cleaning professional, which is also quite common at the first stages.

She was also frustrated by not being able to carry out her other plans related to the household: *since she was at home anyway, she wanted to sort out her things, but she could not even get it started as there she was always hindered by something new to do around Janka.* I asked whether she could deal with that for only five minutes at a time, if she decides only on two things whether she needed them or not. She could proceed bit by bit. She was surprised: *'Well, after all, but ... I haven't even thought about it this way as I prefer to finish sizeable jobs right away, that's the way I like to do things... but, actually,* *I would proceed this way as well, even if at a slower pace...’* After her first astonishment, she became enthusiastic about it, and said *she had many 5-minute gaps a day, so she eventually might be able to proceed with it quite quickly.*

In the following session, she reported that she had been able to tackle all kinds of tasks at home, *she was proud of herself.* However, she still had worries about *doing all household chores like a robot, as if she weren’t herself while doing them, as if they were happening just automatically.* She explained it further: *this state wasn’t a relaxing kind, ‘it isn’t just a little relaxation of the mind when I can switch it off, but I feel unpleasantly distancing from my own self’*. Therefore, I asked her to try to practice a bit of mindfulness and stay consciously present in such cases. For instance, during washing the dishes she might try to observe temperature differences between the hot water and the cool air, or notice the different odors, the texture, weight of the dishes and the sponge, and so on... As sessions went by, she became more and more enthusiastic about her achievements, mentioning that she was paying attention to everything and her sense of being automatic had lessened a lot.

She reported on her joining a Facebook group for moms with babies where they chatted about their questions and worries. At least that was what she thought when she joined. However, within a few days she experienced hostile attitudes and comments on everyday questions. She witnessed critical and assaulting comments several times even when somebody asked a completely relevant question. Although there were some clever and helpful responses, there was a lot of criticism and rebukes. I was shocked to hear that and tried to find logical explanations for such behaviors to ease our strain, and eventually we concluded that she would not leave the group as she received a lot of useful information from helpful comments, and she should neglect malicious remarks. However, the situation got worse, and after a few sessions, she told me she did not dare to put any questions or reply to others because some members would pick on her whatever she wrote. Instead, she sent private messages to comfort women who had been assaulted but whom she agreed with. She took part in several similar chats, she had a positive opinion about these, and they could help each other a little. Nevertheless, in the end, as she had been unable to ignore negative comments she made the decision to leave the group altogether after a few weeks. I feedbacked her how clever she was to spend time and energy with observing herself, staying in the situation up until she considered it useful, but then she was able to change her mind when she finally got fed up.

Her relationship with her husband had also gone through some changes. During the first few weeks, they got really close to each other; she felt that the connection among the three of them was truly intimate and affectionate. However, gradually, some emotional distancing started to develop between him and her. He worked a lot, went out with friends, which triggered mixed feelings in Ann. On the one hand, she knew that spending time separately might be good, but she also felt betrayed. She was disappointed that her husband was not rushing home to see them and he started helping less around the house as well, so Ann felt more and more lonely. The lack of sexual intercourse also meant a problem. Ann tried to avoid them, while her husband would have needed them. I encouraged her to refresh what she had learnt about assertive communication and also encouraged to try to talk to each other. Ann should voice her feelings and wishes but must also listen to her husband's point of view. It is quite common that the husband feels he cannot be part of a close relationship with the baby as much as the mother can, so he becomes an outsider in his own family. In many cases, a father's response is to escape to work. It is essential therefore that the father be part of family life, for example, spend time with the child after bath or take on various tasks day by day. There should also be activities which involve all the three of them actively, and so on. It might broaden their experience of parental roles and intensify their sense of forming a family.

As for sexual intercourses, I reassured her that it was quite a typical female reaction of her to avoid sexual encounters at that period as she was focusing intensely on her mother-role. However, her husband missed them so it bothered Ann as well. We picked on the topic how they could get closer to each other again. I encouraged her to spend more quality time together, and that they themselves should determine what quality time means for them: to watch a film at home, or go to the cinema, take a stroll, or anything they found appealing. Although, at that time, both of them concentrated on their parental roles and functions, they did not cease to be man and woman, husband and wife. They should take the time to snuggle, to please each other. It is important to consciously set aside time for this, and they should be patient with themselves and with each other.

After some more sessions, Ann decided that she was prepared to get along on her own. She felt much better. I completely agreed with her, actually, I felt the same so I had already been planning to discuss to finish of her counseling at that session. We agreed that whenever she needed help she should call me. We also reviewed the issues we had dealt with, the progress she had made and highlighted the things she wanted to continue working on.

Considering that she had never had a disorganized or untidy appearance and she had strength and stamina despite her fatigue and complaints, we found her consultation with a psychiatrist unnecessary. We were able to work with her effectively via simple counseling techniques, such as pre- and postnatal education, attentive and active listening, reframing and summarizing. Developing effective communication skills, relaxation and coping strategies were also embedded in her therapy. I judged these methods appropriate and sufficient for her prevailing condition and energy. Sometimes little things helped her move forward, such as being listened to, without getting any particular advice or plans for solutions. To have somebody simply present helped her face and think over her thoughts. That is why, in the last session, I prefer reviewing the changes clients themselves have noticed, the gains they have made in treatment, the things I was able to help them with and thus they can take it away with them. I always ask them what particular fields they would like to achieve further improvement in. If a client dares to be honest and does not only give me polite answers, I can learn a lot from their responses.

Lessons learnt from this case

Throughout pregnancy, delivery and the whole perinatal period, women face various types of problems. I am often surprised by how effectively even trivial things can help, such as filling an information gap, or just being present to listen to patients so that they can ventilate, ease the tense and have some space and time on their own. With those clients who improve a lot during the counseling process, I often try to identify the things I was able to help them with, although I know that I do nothing earth-shattering. I simply give my clients small bits of help they cannot get from anywhere else. Fortunately, it is often enough to help them move forward. It can even support the development of the fetus, the newborn and the harmony of the entire family.

3. DISCUSSION

The treatment of depression experienced by pregnant and breastfeeding mothers is an important issue in psychiatry today. Using pharmacotherapy in this critical period always requires extreme precaution, mainly in order to protect the health of the fetus and that of the newborn. Monitoring the mental health of mothers in the perinatal period has proven to be useful against depression and anxiety: supportive talks, psychoeducation, developing communication strategies are all methods to reduce mood swings and improve mood. Talking about changes in family roles, preparing for labor, helping parents' adjustment to parenthood are factors that help the entire family. As our case study clearly demonstrates, pregnant women and mothers of newborn babies happen to face various difficulties in the perinatal period and (as it can be seen in item 6 – questionnaire EPDS) the feeling of being overwhelmed is often experienced.

Treatment of perinatal mood disorders might also take its tools from the field of cognitive behavioral therapy that focuses on improving patient social effectiveness and reducing the frequency and strength of negative automatic thoughts. In addition, relaxation techniques are useful to prepare women for labor so that the client can have better chances for vaginal delivery rather than having a caesarean section (Chang et al., 2008; O'Mahen et al., 2012; Saisto et al., 2006).

Perinatal mood disorders and its various complications might induce several adverse effects on the fetus, the pregnant woman, the newborn and the mother. Hence, maternity care with special attention on tracking mood changes throughout pregnancy, labor, birth and the postpartum period is of primary importance. In order to accomplish this goal, screening and monitoring the mental health of childbearing women, before and after childbirth, has been implemented in Hungary, first in the town of Szeged, and subsequently, in several other towns. The screening project is carried out by the Hungarian midwifery service with the help of the abovementioned EPDS questionnaires (Cox et al., 1987). When a midwife – who pays regular visits to families – assumes mood disorder, she can assess the severity of the condition with the EPDS questionnaire, and can refer the patient to the appropriate mental health professionals. This screening program provides a safety net for families by reducing the risk of various perinatal complications; thus, it opens the way for the birth of mentally more and more balanced mothers, infants and families.

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Nikolett Pápay

“WHAT AM I RUNNING AFTER SO SHORT OF BREATH?” THE PSYCHOSOCIAL CHARACTERISTICS AND THERAPEUTIC POSSIBILITIES OF AGE-RELATED INFERTILITY

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1. INTRODUCTION

The focus of the present study is on a specific subset of fertility problems, age-related infertility, which has become a public health problem worldwide and therefore psychosocial aspects it involves should be seriously considered from a health psychology perspective (Macaluso et al., 2010; Somigliana et al., 2016). While at the attitudinal level couples rank the importance of having children high on their list of priorities, the realization often does not occur until around the age of 30 (Kapitány & Spéder, 2018). At the same time, the prevalence of fertility problems increases with age (Committee Opinion [CO], 2014; Harper et al., 2017), reaching almost 50% among women over 35 expecting their first child (Borsos & Urbancsek, 2007). In such cases, however, we are not talking about organ or hormonal “dysfunctions”, but simply about the natural ageing process of reproductive organs and hormonal function (Harper et al., 2017; Somigliana et al., 2016). As a consequence, more and more women are facing fertility problems and need to seek assisted reproductive treatments past the age of 30.

Age-related infertility can be caused by a number of socio-cultural and psychological factors. These include a lack of knowledge about reproductive health, which makes it difficult to make timely and informed decisions about having children. This means that women and men of reproductive age are often unaware of the basic concepts of fertility and infertility, the nature of biological phenomena, and therefore it is an important task for professionals to raise fertility awareness among those concerned (Bunting & Boivin, 2008; Pápay, 2013; Pápay & Gellért, 2015).

Although assisted reproductive treatment often raises hope, it is accompanied by a number of psychological challenges: it is characterized by a constant experience of failure and loss, it can induce chronic stress, it violates the intimacy and sexuality of couples, and it places the couple living an otherwise healthy and active life in a “patient” status (Pápay, 2013; Szigeti et al., 2015). The clinic itself is often a source of stress due to poor communication and non-person-centered care (Boivin, 2009). Therefore, couples need effective infertility-specific coping strategies. The cognitive restructuring of the situation (e.g. finding alternative life goals) or emotional approach strategies (e.g. peer support or strong relationship cohesion) (Schmidt et al., 2005; Terry & Hynes, 1998) both count as adaptive coping.

Cognitive representations also strongly determine coping styles, as well as attitudes and emotional responses to treatment (Leventhal et al., 1984; Pápay & Gellért, 2015). Infertility can appear as an "enemy" to be defeated, in which case the emotional response is angry opposition; as a loss, which can trigger grief reactions and be associated with a depressive mood; as a punishment, which can imply feelings of fear, of self-abandonment; as shame, which can reinforce feelings of stigmatization in the person (Benyamini et al., 2004).

In addition, it is worth drawing attention to the crucial role of representations of motherhood/parenthood, as mapping these can help predict later reproductive behavior, which can also help us better understand age-related infertility. Several important factors may play a role in the development of attitudes towards parenthood, such as early socialization (family patterns) or culturally shaped beliefs (Pápay et al., 2014; Vajda & Kósa, 2005).

Finally, I would like to briefly highlight the therapeutic methods that have been shown to be particularly effective in reducing infertility-specific distress based on research findings (Boivin, 2003; Pápay, 2015).

a. Relaxation techniques: having productivity problems, it is necessary to practice relaxation techniques to help in a variety of distress situations. Examples include breath monitoring, progressive relaxation, or autogenic training, which can also improve self-knowledge (Domar, 2002; Linden, 1994; Pápay, 2015).
b. Guided imagination. It is beneficial to integrate relaxation techniques with imagery work. Birman and Witztum (2000) found that guided imagination helps the process of becoming pregnant by processing negative emotions and blockages related to motherhood through imagery techniques.
c. Reframing maladaptive thoughts: the infertility life situation can invoke a number of maladaptive thought patterns that lead to distress. Reframing can help reduce infertility-specific distress and increase psychological well-being (Domar, 2002).
d. Schema Therapy: Schemas can be used to understand and systematize persistent life problems, so maladaptive patterns associated with infertility can also be revealed (Young et al., 2003). Through schema therapy, couples can practice self-reparenting and self-care, and can experience the self-power of the healthy adult part of themselves.

In conclusion, in the case of age-related infertility, mental balance can be most effectively addressed within the holistic, bio-psycho-socio-spiritual framework of health psychology. A complex therapeutic toolkit can also help to maintain long-term mental health, even for those who have to give up on childbearing definitively.

2. CASE STUDY: FOCAL POINTS IN THE THERAPEUTIC WORK OF A WOMAN OVER 40 WITH FERTILITY PROBLEMS

The case presented here is fictive, i.e. it is composed of characteristics observed in several patient cases in order to get an overall picture of the main psychosocial concomitants of the age-related infertility problem in practice. Therefore, the common feature of the sources serving as the basis of the fictive case was that no inherent organ dysfunction underlying the fertility problem has been diagnosed and only the age (over 40 years, considered high for fertility) posed a risk factor in becoming pregnant.

Anna is a 42-year-old woman with fertility problems, who sought help for her anxiety problems, chronic fatigue and extreme mood swings. She and her partner decided to start consciously to have children six years ago, when she had already passed the age of 35. After a year and a half of unsuccessful attempts through natural means, they started assisted reproductive procedures; in the last five years, Anna has had six failed IUI (Intrauterine Insemination) treatments and five failed IVF (In Vitro Fertilization) treatments. They have also changed institutions twice over the years, because they felt they were not always getting personal attention. The series of losses took a heavy emotional toll on Anna, but she did not have the time or the means to grieve these losses properly. During the tests, no organ-related or hormonal abnormalities were found in either of them, and the infertility specialist simply pointed to Anna's age as a possible cause of her difficulty in conceiving. When I asked why they had waited so long to have children, Anna mentioned three factors:

a. "The time for it has just come". Anna and her partner married early and spent their time building their careers. Anna works in an executive post in a multinational company, and it took her some time to position herself properly in her profession. The years that followed were spent building up her existential security (securing her finances and building a house). Anna says that this was very important for them in terms of having children, but now she feels that they should have reversed the order, as she does not enjoy her job or the nice house without children.
b. "We didn't think age would matter so much, that we would have to try so hard". Anna and her partner are both have university degrees, which means they have a high socio-economic status. Surprisingly, they were not aware of the basic characteristics of reproductive function and the role of age in determining it. Research has also confirmed that couples tend to underestimate the risk factors related to their reproductive health (Pápay, 2013; Pápay & Gellért, 2015; Pedro et al., 2018). Anna's case confirmed that fertility awareness does not necessarily go hand in hand with the intention to have children, and even among highly educated couples, psychoeducation and timely information is needed to help couples make an informed decision.

c. “We are believers, so for a long time we left it up to God to decide when the child would come to us.” Several studies have confirmed that in infertility, faith (regardless of denomination) can be associated with better coping and thus lower distress, as spiritual beliefs can help to cope with difficult life situations through meaning-making processes (e.g. Folkman, 1997; Schmidt et al., 2005). However, as we see in Anna's case, it can also become a hindrance in case it evokes the expectation of a miracle. The emotionally avoidant coping strategy (things will work out, I accept it) of persons with external locus of control can be associated with indecision and passivity (Rotter, 1990). On the other hand, it is worth considering that infertility is a low-control stress situation. As a consequence, we often find that people with internal locus of control (I'll deal with it) often experience intense distress due to their excessive need for control, as they cannot solve this situation by problem-solving strategies alone (Terry & Hynes, 1998). It is, therefore, necessary to hand over and release control to some degree, as there is no problem-solving method that can guarantee the arrival of the child. It is therefore worth optimizing the external and internal locus of control, identifying the activities that can be kept under control (e.g. appropriate health behavior, elimination of risk factors, decision-making about interventions, identifying alternative life goals, deciding on the final timing of treatments,) and letting go of control for the rest of the process (this is where beliefs can play a significant role).

2.1. PSYCHOSOCIAL EXPERIENCE OF INFERTILITY

I am going to consider Anna's infertility-specific psychic state in a holistic approach, in three dimensions: intrapsychic, relational and interpersonal.

2.1.1.

Intrapsychic: Anna was characterized by a narrow focus (I can't think about anything else, I only think about this), a persistently high level of distress (irritability, anxiety reactions) and a dominance of negative emotions (anger, sadness, feelings of hopelessness). The experience of infertility was most reminiscent of an emotional roller coaster, with emotional responses matching the rhythm of the menstrual cycle: initially positive emotions such as hope and optimism, and later, at the onset of menstruation, negative feelings of disappointment and failure. There were also feelings of self-blame and guilt (this is some kind of punishment, I must deserve it, I wouldn't be a good mother). Chronic infertility was associated with life cycle blockage and stagnation, as Anna was unable to take on the parenting role she wanted and therefore experienced an identity crisis. She could not fulfill her potential in caring for others or in productivity, she experienced that she was worthless, both in terms of her femininity and in her more general human quality (If I can't be a mother, I'm not worth anything, I'm not a real woman).

2.1.2.

In terms of their relationship, Anna said that the crisis has strengthened the bond with her husband. Although, there were low points, she and her partner never lost trust in each other. For them, infertility is a shared burden, they are both equally affected by it, so during the test tube baby treatments her husband always stood by her side and helped her in whatever way he could (e.g. by administering the hormone-stimulating injections). The main problem was their different coping strategies, i.e. while Anna was very emotionally involved and needed regular emotional sharing, her husband preferred to help her and engage in activities that were positive and recharging. These two needs were often in conflict. Anna also feared that if they remained childless, the relationship would become empty, and they would lose their common purpose. So, she saw childlessness as a destructive threat to their relationship in the long run.

2.1.3.

Most of the problems arose on the social level, as Anna felt stigmatized because of her infertility. She believed that childless couples were detested by their social environment and therefore thought of herself as a sinner, being rejected, who could not fulfill the role of a woman as expected by society. As a consequence, her basic communication strategy was secrecy. At work and among her friends, no one knew about her desire or attempts to have children. Even her close family did not know about the assisted reproductive treatments, and she only told her mother about the inseminations, but not about the test tube baby procedures. This confinement deprived her of social support and made her completely isolated. Her feelings of shame could not diminish because she did not receive external validation and acceptance from her loved ones. She thought of motherhood as an external expectation (extrinsic motivation), believing that if she did not have children, she would be considered worthless in the eyes of others, also by herself. This self-imposed pressure led to more anxiety and frustration. In addition, people around her, not knowing Anna's situation, would often make comments and ask the wrong questions, against which Anna was defenseless or became angry, which she was unable, or afraid to express. She forced herself into role-playing, which prevented her from being her true self.

2.2. Therapeutic Goals and Methods

Our therapeutic objective was primarily to reduce Anna's infertility-specific distress. It was also important to reframe her dysfunctional thoughts and to process her previous failed pregnancies and losses. In addition, I facilitated the formulation of alternative life goals of having children. We signed a contract for ten sessions, focused on problems related to infertility. In terms of methodological choices, we worked mainly with relaxation and imagination, cognitive behavioral and schema therapy techniques, in addition to supportive conversations.

3. KEY STAGES OF THE THERAPEUTIC PROCESS

3.1. AUTOGENIC TRAINING AND RELAXATION

In order to reduce the level of distress, we started to learn autogenic training exercises, which help the relaxation response of the body, furthermore have a self-knowledge development effect thanks to writing a journal regularly (Schultz, 1932). As a result of the training, Anna became increasingly able to recognize her own emotional states and dysfunctional thoughts. She realized that her body was constantly in a state of tension, as if she had to keep herself in a constant state of readiness. Through the use of progressive relaxation techniques, she was able to experience a sense of loosening up and taking control over her body. By the end of our work together, she was able to incorporate autogenic training into her daily routine, which will serve as a resource for her in the future.

3.2. GUIDED IMAGINATION

I used guided imagery to increase her self-efficacy, as it was important for Anna not only to receive reinforcement verbally but via other ways too. The imagery served to recharge her and to restore her sense of inner stability. The images chosen included the image of a safe place, the healing spring that strengthens the regenerative processes of the body, the 'my private garden' image that promotes growth, unfolding and self-care, or an imagination of the much anticipated guest that frames the helpless waiting of infertility in a positive way.

The safe place was a comfortable armchair, in which she rested, enrolled in a soft blanket. The tactile stimuli, the warmth, the calm, quiet environment, recharged and enhanced her sense of security. She experienced that she is able to relax and calm down. After the imagination, she expressed that such moments of relaxation were completely missing in her life, but she really needed them. In order to put this into practice, she had to choose an activity that gave her a sense of pleasure, and which was independent of the question of having children. She chose yoga and incorporated regular online yoga classes into her daily schedule, and thus also began to develop a more positive health behavior.

The healing spring was clear spring water with a pleasant consistency that came from a rocky gorge. Anna washed her hands, face, and whole body in it, feeling how it energized and recharged her body. She drank from it and experienced her internal organs being healed and refreshed. She concentrated particularly on her pelvic organs, ovaries, and uterus, as the feminine parts of her body image have been under a lot of strain due to her recent failed fertility treatments.

The image of my private garden was set up as an analogue experience of inner maternal impulses and caring. Anna's garden was a harmonious area, isolated from the outside world, with trees, bushes, and flowers. In the imagination, she watered the plants, protected them from bugs and then watched them grow in the sun from a rocking chair. Following the imagination she reported feelings of inner peace and self-efficacy. She decided to plant five different trees in her own garden, commemorating her unsuccessful test tube treatments. It was the first time she had given space to her feelings of loss. Although she had previously thought the best strategy was to forget, she now sees things differently and wants to remember them.

The aim of the much anticipated guest imagination was to reduce Anna's frustration about anticipation. Anna told us that regarding infertility it is very difficult for her that she has to be waiting all the time. It is a transitional state in which the plan to become a family gets stuck. In Anna's case, this stagnation has taken many forms: for example, the room that was originally intended to be the child's room has become a storage room for accumulated excess belongings, or they have not planned a trip abroad or a holiday for years not wanting to spoil the possibility of getting an appointment at the fertility center at the same time. In the imagination, the apartment had to be decorated for an expected guest in order to make the guest feel as comfortable as possible when they arrived. Anna decorated everything beautifully, cooked, made presents and then took care of herself, relaxing and listening to music. After setting up the picture, she said it was especially important for her to experience that waiting can be positive; it can be a time to recharge and regenerate. It's important to take care of yourself because it does matter what physical and psychological condition you will be in when you do get pregnant and have your baby. The imagination has led her and her partner to tidy up the room and put an end to its temporary nature. They have created a relaxing space where they can recharge by listening to music, or it can be used for meditation exercises or playing games.

3.3. SCHEMA THERAPY TECHNIQUES

In order to overcome Anna's feeling of worthlessness, I used schema therapy. Her dominant schemas were identified, and besides defectiveness, unrelenting standards and approval seeking schemas proved to be dominant. The latter was primarily responsible for the anxiety mobilized by the idea of childlessness. It turned out that, instead of developing a realistic self-image and self-care, conformity to others (compliant surrenderer schema mode), suppression of one's own needs and self-blame (critical parent schema mode) became the most important maladaptive coping strategies. Through empathic confrontation, we came to the realization with Anna that she needed to learn to be more forgiving of herself. We defined that first she has to learn to take care of her own inner child in order to be a good parent later on, so that she can take good care of others. Through schema-imagination, we explored the emotional needs of her vulnerable child part, and then through chair work (in which we visualize different schema modes and ego states by placing them on chairs, exploring their interconnectedness and communicating with them) we managed to strengthen the healthy adult part, reducing the influence of the critical parent part.

3.4. COGNITIVE REFRAMING

Anna had a number of maladaptive thoughts about infertility that needed to be reframed. We identified Anna's key phrases (“Without a child, I am worthless”, “If I don't succeed with the last test tube, my marriage is over”, “Childless couples are detested”) and then tried to reinterpret them in an adaptive way.

“Without a child, I am worthless”: as we have seen, Anna had always linked her own value to meeting external expectations (as she had done with motherhood). In the course of our discussions, she realized that she did not have to satisfy others, but she had to be prepared to accept herself, even if she ended up childless. Approaching it from a more realistic self-image, she was able to appreciate the positive qualities she already possessed, independent of motherhood (e.g. her conscientiousness, perseverance, reliability). In the end, she came to the conclusion that a child is of great value in life, something she still longs for, but she could use these positive and lovable qualities in other ways too.

“If I don't succeed with the last test tube, my marriage is over”: the relationship aspects were discussed in a session that Anna and her partner attended together. It turned out that the husband is much less radical than Anna when it comes to having children. His wife's mental and physical health is very important to him, and he can only imagine having children, if their physical and mental health is maintained. He is a cheerful man, and thanks to him, they have many hobbies in common: hiking, sailing, dogs, and all of this can bring them joy even in a childless life. I also drew their attention to the fact that their relationship was strong even before they wanted children, and they planned and progressed through life together. I am sure this will be no different in the future. It is also important that they mutually accept each other's coping strategies. It is understandable that the husband cannot always focus on the emotions of infertility, it is also important for him to be able to step back and recharge, because he feels that this is how he can “hold the relationship together emotionally”. However, this should not mean ignoring Anna's emotional needs. They have agreed to set aside regular times when they will focus specifically on feelings about infertility, which he will not trivialize, and also times when they will try to enjoy some kind of activity together, regardless of the issue of having a child.

“Childless couples are detested”: the fear of peer judgement was very strong in Anna. A sense of guilt and shame about infertility is often still present in the public mindset, which may be reinforced by unsolicited, unsupportive interaction with the environment (e.g. trivialization, avoidance, scapegoating, Mindes et al., 2003). Since Anna's social space was restricted, and she had a secretive communication strategy about her fertility problem, she had no chance to get the validation she needed from her environment. To do this, she had to open up and fundamentally change the way she communicated with family and friends. According to her, her mother has been very understanding in all the difficult situations she has faced in her life, so we got her to talk to her about their current situation. A more emotionally open and intimate communication has helped Anna to overcome her anxiety in social relationships.

As a result of our discussions, she also changed her communication strategy at work and shared her infertility with a childless colleague. It turned out that her colleague had a similar problem but was experiencing an earlier stage: she was just considering to take part in assisted reproductive treatment. The two women became closer during their conversations ("we shared our fate"). In addition, Anna was able to share her experiences and see that she herself can help others. As a result, she started to feel competent and useful again, and her self-esteem and self-confidence increased.

3.5. ALTERNATIVE LIFE GOALS

The discussion on alternative life goals was primarily aimed at relieving Anna's infertility-specific anxiety, as the success rate of test tube baby treatments decreases radically after 40 years of age, so it is important in all cases to have an alternative choice to having treatment. I reassured her that thinking about other things does not mean giving up the hopes of bearing a child, it may simply result in less anxiety during treatment if she has a viable Plan B up her sleeve. In fact, narrow, all-or-nothing thinking increases distress, high levels of which can even have a negative impact on the process of getting pregnant, so it is beneficial to reduce infertility-specific distress, not only for psychological well-being, but also for the chances of getting pregnant. So far, the obstacle to thinking about possible life paths and activities was that Anna had very strong expectations of herself in terms of motherhood (I can only be valuable if I become a mother), so that no other alternatives were acceptable to her. As cognitive therapy tools helped her reduce these expectations, she was able to look more closely at her real feelings about having children. I think that formulating her thoughts on this was one of the most important moments in the therapeutic process, as her mature, adult self was expressed in a responsible, yet self-accepting way through these sentences: What actually am I running after, so short of breath? Maybe it's no coincidence that I started thinking about this so late? When I think about it, there were a lot of other things in my life that were important that I prioritized over having children... Maybe I need to take responsibility for these past decisions and, without blaming myself, admit I what had happened. This train has left the station forever, rather than continuing to run after it like crazy until I am completely out of breath, destroying my body, my soul, my partner, our life together. In the last few years, I have hardly had a happy moment in my life, which makes me think... It would be painful to let go, to mourn, because of course I am still longing for a child, but at the same time, it is possible that I have a better chance of being happy in another way, because the way I am living now, I am very much unhappy.

As an alternative life goal, Anna first mentioned her career. She said that her career had been stagnating for years because she had never dared to take a higher position, fearing that she would get pregnant at the same time. This stagnation has meant that she had not been enjoying her job for a long time, even though she had liked it originally. Now she was in a situation, where she had been offered a position in international relations, which would have involved a lot of travelling. She finally decided to accept the challenge. Anna was much more enthusiastic and motivated as a result, and later reported that she had less time and less desire to think about her infertility problem.

The other aim is taking care of animals. Anna said that she would love to work more intensively with dogs and training them if she had more time. But so far treatments have taken up all her free time. Finally, she decided that if the next test tube baby treatment didn't work out, she would start a course about dog training.

4. Completing the Therapy

By the end of the 10 sessions, Anna's anxiety had decreased significantly. Her relation with her husband strengthened, and she began to trust her husband more and trust that they could have a happy life even without a child. She started to change her secretive communication strategy, sharing her problems with those close to her, and received more and more reassurance. Her tensions at work also reduced as she got a confidante there and began to enjoy her job again. She was able to reframe her dysfunctional thoughts about infertility. Her self-esteem increased and her attitude towards parenthood became more intrinsically motivated rather than conforming to external expectations.

5. Discussion

As we have seen, age-related infertility is becoming increasingly common among fertility problems, and it is therefore necessary to better understand its psychosocial aspects and to develop and implement effective interventions to help those affected (Somigliana et al., 2016). Overall, what aspects should be considered when designing them? What are the future challenges in this area?

In this study, I have presented a number of infertility-specific psychological phenomena that outline the scope of this work. The tasks that have emerged can be divided into two broad groups: (1) one aimed at reducing infertility-specific distress, (2) the other at shaping meaning and helping to find a new identity. The two sets of tasks certainly overlap, as the cognitive restructuring of infertility identity reduces distress and leads to a more positive psychological state (Folkman, 1997; Schmidt et al., 2005). What they differ in is rather the focus of therapy: in the first case, a new state of equilibrium is sought within the infertility life situation, while in the second case, the issue of infertility is placed in a broader context, and in addition, letting go and the formulation and acceptance of alternative life goals are supported. In the following summary, I will briefly show how it is possible to thematize these two tasks. Finally, I will also provide an insight into the preventive tasks related to age-related infertility.

5.1. Tasks to Reduce Infertility-specific Distress

As we have seen, age-related infertility can have a wide range of emotional responses, so it is important to provide space for a diversity of emotions and ensure acceptance. Many of the negative emotional responses are also taboo in the social environment, e.g. feeling angry or jealous about someone else's motherhood is generally forbidden. If these emotions are made acceptable in the therapeutic space, it can significantly reduce the distress experienced by those affected.

Achieving psychological balance is essential not only within the individual, but also in her relationship and in the social space. In age-related infertility, strengthening relationship cohesion is particularly important, as the experience of belonging can provide an emotional base for processing many experiences of failure and loss (Schmidt et al., 2005b). The sustaining power of close family and friends is equally important. This requires the development of appropriate communication strategies. Secretive communication can lead to isolation and increased distress, overly open and permeable communication can lead to a loss of intimacy and increased vulnerability (Schmidt et al., 2005).

Another important social scene is the medical environment, the place of assisted reproductive treatment. Research has shown that client-centered care in clinics can reduce infertility-related distress. From a health psychology perspective, effective training of the medical environment in the practice of supportive communication is of paramount importance. It has been proven that age-based infertility requires a more accepting, less directive, partnership-like attitude on the part of medical staff (Palmer-Wackerly et al., 2019).

In order to reduce distress, it is crucial to develop appropriate coping strategies: to increase the frequency of emotion-expressing and meaning-seeking coping styles aimed at reassessing the situation, while decreasing avoidance and the expectation of miracles (Pápay et al., 2013; Schmidt et al., 2005; Terry & Hynes, 1998). Working with couples, it is worthwhile to bring the coping strategies of the partners closer together: to teach couples how to accept when they are not coping with fertility problems in the same way. Overall, it is essential to increase flexibility and resilience, as a narrowed emotional focus, all-or-nothing thinking, and the emotional burden of "last chance" is largely responsible for negative emotional responses.

It is also important for couples to learn to optimize situations of letting go and control. On the one hand, we should promote personal control where it is possible: in health behaviors (e.g. healthy eating, avoiding harmful addictions, exercising to improve fertility) or in decision-making situations (appropriate choice of doctor and institution). On the other hand, we should help those concerned to let go of situations over which they have no control. Closely related to letting go is also the need to allow space for processing losses, as in age-related infertility, many forms of loss can occur, often in a blocked form due to negative self-protection mechanisms (I did not want it to hurt, so I preferred not to think about it) and time pressure (I felt I had no time to stop).

Finally, it is also important to emphasize that an individual's dysfunctional emotional states may not only be of intrapsychic origin but may also result from the wider socio-cultural context in which the problem is embedded (Pápay, 2013). Therefore, we need to address the socio-cultural pressures on people with infertility, the expectations of parenthood, the stigmatizing effects of infertility and the negative impact of these on self-image (Covington & Burns, 2006).

5.2. Tasks to Help Find Meaning and a New Identity

In the case of age-related infertility, it is particularly important to put the life situation into a broader context. This requires looking outside, questioning many of the aspects that seem obvious. For example, the definition itself; is age-related infertility really infertility? If we approach this question from the perspective of representations of health and disease, it raises very special dilemmas. Indeed, from a medical point of view, there is no real disease; reduced fertility potential can be interpreted as a natural biological event, as the body proves to be fertile only during a certain time interval in human life (Somigliana et al., 2016). Around the age of 40, women's reproductive functioning reaches this biological limit, so it is perfectly natural (and healthy, evolutionarily adaptive) for the reproductive window to close at this time. On the other hand, thanks to assisted reproductive techniques, this biological limit becomes much more flexible, so that often even after the age of 40, couples choose artificial insemination in the hope of a possible pregnancy. And as medical treatment begins, images of the body and health change: positive perceptions are replaced by various representations of illness ("my ovaries, my uterus are shameful, I have been abandoned", "I can't produce enough eggs, I am not a real woman"). In addition, hormone stimulation can often lead to real secondary physical problems (e.g. cysts, fibroids), which can reinforce the perception of physical dysfunction and the development of the identity of infertility in the affected individuals. Previous beliefs about the body (e.g. my body is healthy, it functions well) change and take on negative emotional meanings (I can't trust my body, my body is against me, what is most natural for others is not for me) and the couple who previously considered themselves to be perfectly healthy take on a "patient" status. Considering all this, cognitive reframing and facilitation of decision situations is of great importance. Cognitive reframing can affect self-image, body image, sexuality, and attitudes towards having children. For the latter, it is necessary to explore family patterns and understand internal representations of motherhood/parenthood, as these very often provide the psychological characteristics of attitudes towards having children, and may be responsible for anxious or depressive emotional responses (Pápay et al., 2014). Age-related infertility often combines the motive of consciously preparing for motherhood (Create an existence before the child arrives) with the motive of meeting expectations (Becoming a mother is mandatory). The former is responsible for the postponement of having children, the latter for strong feelings of guilt, shame and anxiety. As the client in the case study put it: I am actually running after a train that is already about to leave. While it was on the platform, I didn't really care. Once you manage to get rid of feelings of guilt, it is easier to turn to alternative life goals. Finding a new resting place is in fact based on the realization that, in the end, any life situation is more acceptable than the temporariness of infertility. It is likely that any alternative choice will be associated with a higher psychological well-being, whether it be adoption or a childless lifestyle – the point is that it must ultimately fit systemically with the individual's redefined needs. And finally, any successful adaptation requires that we can take responsibility for our choices, even if this sometimes involves painful renunciation.

5.3. PREVENTIVE TASKS CONCERNING REPRODUCTIVE HEALTH

The analysis of the psychosocial aspects of age-related infertility has also highlighted the need for health psychologists to develop effective psychoeducational programs in the field of reproductive health to enhance fertility awareness (Bretherick et al., 2010; Bunting & Boivin, 2008; Pedro et al., 2018). Considering the biological aspects of fertility outlined above, it is essential that knowledge about fertility, infertility and reproductive health behavior is imparted in young adulthood, facilitating timely and informed decision-making about having children. The target age group is therefore between 18 and 25 years. However, an important dilemma regarding the target group is the question of motivation, especially for young people in their early twenties. At this age, the idea of becoming a parent is in most cases not yet in the foreground, which is why such a program on infertility or its risk factors may be irrelevant for them. Taking all these factors into account, the message of the fertility awareness program must be very carefully formulated so that participants do not perceive it as pressure or expectation, as this could lead to considerable resistance, which could even mobilize behavior that could be counterproductive. On the other hand, the implementation of the program also requires professionals who can think about reproductive health in an interdisciplinary way, who are familiar with the medical-biological background, the psychological aspects and the social context. Health psychologists may be particularly suited to this task, as they have a holistic approach, especially if their knowledge is complemented by appropriate knowledge of fertility and infertility. If young people can be made more aware of reproductive health and their knowledge of fertility can become more accurate, the next generation may have fewer age-related infertility problems to deal with and less suffering because of not having made the right decisions in time. A preventive health promotion program with the objective of increasing fertility awareness could be the right direction to start on this path.

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Nóra Árvai

PSYCHOLOGICAL TREATMENT OF ENDOMETRIOSIS AND SUPPORT IN COPING WITH THE DISEASE

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1. INTRODUCTION

Endometriosis is still a mysterious disease that afflicts affected women during their fertile years. In fact, the disease can appear as early as the first period and menopause may not relieve the symptoms. (Rogers et al., 2009).

The leading symptom of endometriosis is chronic pain, which is mostly localized in the lower abdomen, the pelvic area, but can also radiate to the waist. Relieving pain symptoms is the main motivation for women with endometriosis to see a doctor. (Siinai et al., 2007)

> It is an interesting fact that the degree of pain is not necessarily related to the size and extent of the endometriotic nodules.
>
> Fertility disorders, difficulty conceiving, is the second most common reason for women to see a doctor. It can be assumed that endometriosis can cause fertility difficulties both mechanically (by adhesions, tubal occlusion, etc.) and by inhibiting ovarian migration, fertilization, and implantation (Van den Broeck et al., 2013). Difficult conception and possible complete infertility are symptoms that are also worth mentioning from a psychological point of view, as they greatly affect the self-esteem, coping ability, and relationship dynamics of those affected.

The disease affects 10–15% of women of childbearing age and 3–5% of women after menopause. So it can be observed that at least one in 10 women is affected, so there are about 176 million women around the world suffering from this disease (Árvai, 2012).

The establishment of a diagnosis often lasts for years: an average of 6-8 years, and an average of 8 doctors take part in providing the diagnosis. Rolling up a wide range of symptoms can in many cases put patients on a long patient career path until one remembers that organ-specific complaints are associated with the menstrual cycle. By the time patients are diagnosed, they are often exhausted, frustrated, and because they have countless completely negative findings from many places, they eventually believe that we only have the problem in our "head" (Árvai, 2016).

Endometriosis can negatively affect the quality of life, relationships, sex life, and ability to work of affected women. Patients are more likely to report anxiety, worries about the future, and are more likely to experience depression, mood disorders, and often strong guilt.

The following case study provides an insight into my psychological work with a woman with endometriosis.

2. CASE STUDY

For ethical reasons, the case presented below was compiled by belnding 3 similar cases. Maria's story is a good example of the importance of health psychology and health sociology in practical helping work.

2.1. THE SOURCE OF THE REQUEST

Maria is a thirty-eight-year-old, restrained-looking woman who is a little embarrassed when we first met, but she became more relaxed soon. The first problem to be addressed in the interview is that she feels worthless as a woman. She is often anxious, and she is also suffering from the tension associated with fertility difficulties. Although she made her appointment through the online reporting system, both her family of origin and her partner welcomed her decision.

2.2. ENCOUNTERS WITH THE CLIENT AND THE PROBLEM AS THE CLIENT PRESENTS IT

During the encounters with the client, of course, the story is constantly forming and her goals are changing too. Maria is married. She reports anxiety and depressive symptoms, the cause of which is that her ovaries have been destroyed on both sides due to her illness, one has been removed and the other is impenetrable, so she is forced to resort to assisted reproduction. She had a hard time processing it, she showed signs of anxiety, she folded her hand, bit the edge of her mouth, she even cried once.

The disease – stage III endometriosis – was revealed during laparoscopic surgery, which was performed because she had wanted to get pregnant for two years, but she tried unsuccessfully. Maria's doctors said she had no chance of conceiving naturally. She was very scared of the fresh diagnosis, she wanted to get help to prepare for the IVF program, which she was quite wary about at first.

She said it is very difficult for her to accept that she cannot get pregnant spontaneously. She was afraid of the side effects of the IVF program. She heard and read a lot of bad things, from the recurrence of endometriosis to the risk of breast cancer later. Infertility has a serious negative effect on female self-esteem, so women with endometriosis often see the disease as a constant threat, a kind of time bomb that can reappear at any point in their lives. In the case of Maria, all these difficulties arose. She also feared that the IVF program would take away the romance of expecting a child and ruin her relationship. She felt embarrassed to get pregnant with IVF because it meant she was unable to function properly as a woman.

In Maria's case, it was important to assess the level of prior knowledge about the disease, to gently correct incorrect/excessive information, to educate patients, and to teach them how to use the forums and groups available on the Internet in a way that benefits them, not just "The sad stories drag her down." She read that the Catholic Church had a rejective opinion about the IVF procedure and therefore did not know how to tell her parents about the problem because they are faithful Catholics.

The situation was aggravated by the fact that shortly after our first conversation, excerpts of an interview with a highly respected church official appeared in the news according to which the IVF program was a sin that should be eliminated. These articles shattered Maria and while she was speaking about this, her voice was trembling, on the verge of breaking down in tears repeatedly. She called herself a "flawed" woman, struggling with guilt, fearing that due to her fault they would not have a child, and couldn't imagine what other meaning could be found in life if someone did not raise a child.

In addition, she felt left abandoned by the health care system. She said she never had the opportunity to ask questions from the doctors, was treated on a treadmill, paid tens of thousands for five minutes she spent in their offices, with doctors who said he saw only the bill she'd pay, not a young woman yearning for reassurance. She did not dare to share her worries with her husband because she was afraid that Peter would mentally collapse then, and she would no longer be able to bear it if she saw her husband suffer because of her illness and its consequences.

Maria's typical way of thinking was catastrophizing. Everyone encouraged her that even the first IVF could be successful because her uterus had a healthy hormonal household. For her needing an IVF already meant that she would probably never have a child, was worthless as a woman, she was alone with her worries Her husband could leave her any time once he realizes this is her "fault".

An important element of our initial conversations was a kind of education, in which I provided real, credible information about the nature and course of the IVF program and the real data on possible side effects because, in the vast majority of the Internet, I encountered negative stories. I passed the information to her by sitting down, leaning back, offering her a seat, too, and asking her to put questions that keep bothering her that she hadn't had a chance to ask before. This ensured that we had time to talk to each other. She later said she felt that now we didn't have to stop as long as she had unanswered questions about IVF. That was very good for her, so we were able to overwrite her previous bad experience with the way too busy medical staff. We also discussed in detail exactly how the IVF program works and thereby transformed the exaggerated ideas in Maria's mind that mystify the process. We also talked about an IVF being neither a panacea nor a child producing factory. According to Maria, one sentence was very important for her which was that if a sperm did not want to "stay" in the ovum, it would not, not even during IVF, so this was not "rape" against nature, just a little help for the cells when they want to meet, but they cannot because of the inadequacy of the physical conditions.

The cold terms of stimulation, suction, fertilization, implantation were renamed the rendezvous of the cells, which helped Maria find the missing "romance" in the process. In this way, we managed to frame the IVF program itself from a violent, aggressive process to a helpful, beneficial process that would help Maria to become a mother.

2.3. RELATIONSHIP WITH THE CLIENT

Fortunately, Maria had no trouble talking about her thoughts with someone who was not religious herself. This is a very sensitive topic that requires increased care on the part of the helper. It builds a relationship of trust between the psychologist and the client, establishes the rapport when we can talk honestly about this helping relationship. It was reassuring for Maria that we exchanged a few sentences about this. It is the individual decision of the professional helper to decide how much and what kind of information to share with the client about themselves, and this is sometimes an intuitive process.

In the case of Maria, these few sentences strengthened her confidence and especially thanked me for my sincerity. She said it was like an invisible wall had fallen between us. It was even important to her that I was willing to "take a step" and confirmed that I imagined that if there is a God, I think God is very happy that IVF exists because for God life is the greatest value. Life is at the end of the process and God's blessing also accompanies this process. I have tried to deal with religious issues very carefully throughout our nine consultations and there was only one occasion when we were discussing these issues.

2.4. SUMMARY OF APPLIED TECHNIQUES, TESTS, RESULTS OF OTHER EXAMINATIONS

2.4.1. COPING SKILLS, RESOURCE MAPPING

The Body Sculpture Test was one of the first tests we did with Maria. This test was validated in Hungarian by Fehér Pálma and used in somatic patients (Fehér, 2013). She formed a fragile, thin, recumbent human figure out of clay. She worked rough, fast, almost in a hurry. She finished it soon. She carved three lines on the face of the two eyes and the mouth with her fingernail in a recumbent shape and punched three tiny holes in the abdomen, illustrating the traces of endometriosis surgery. The belly of the recumbent figure was convex, she looked like she was pregnant, but when Maria tried to set up the figure –the figure was lying when she was shaping it but it was originally intended to be a standing figure – she almost angrily emphasized that she was not pregnant, just bloated because of endometriosis. The statue was unstable, it couldn't be made stand up and Maria couldn't even let it go, because one or another limb fell of it whenever she tried. She repeated it for a couple of times and then became so angry that she threw it all in the trash, saying this is how much the figure was worth "Just like me…"

Maria showed a lot of anger towards herself and her body at first, she felt that she had failed, and her body had let her down. She also felt anger toward doctors who did not realize in time that her infertility may be due to endometriosis. It only added to her frustration and distrust of the medical staff that she felt she had not been properly cared for. The medical staff left her with unanswered questions.

We discussed who the ideal doctor would be, whom she could trust, what qualities the doctor should have. What aspects were important to her, and what wishes she would be willing to enter a compromise on. Based on these, the doctor who made the diagnosis did not meet Maria's expectations, but an important moment was the discovery that she did not have to remain defenseless, and the control over the choice of institution and doctor was in her hands. There is no point in rushing the process, nothing happens if she starts the program a month later, once the right location and support staff have been found.

I used direct suggestions to describe her near-future situation, instead of "if" I said "when you found the right doctor", and so on (Varga, 2013). I was aware that "finding the right doctor, the right institution" could potentially lead to a time-consuming run from doctor to doctor, not being able to commit oneself, but for Maria, this was out of the question: she did her research for a doctor, went directly to the doctor she had chosen, and she had a very good first consultation with her indeed. Finding the helper she trusted increased her ability to accept the situation.

We often went back and forth in our conversation to verbalize her goals, that her greatest desire was a baby, and that the IVF program is the only way to achieve this goal of hers. We formulated and stated what the purpose of the procedure was and why it was good for her. In addition to the goal-setting, we also used the method of positive visualization, I made her imagine herself pregnant with a baby, and then as a happy mother of it. I asked her to imagine how it feels to hold her baby in her arms, and her face lit up while she was imagining her dream. I said then that experience has shown that when she'll hold this soft, sweet-scented, sniffling baby in her arms, her baby, she won't even remember whether that it had been conceived in an IVF or spontaneously, it won't matter at all.

For Maria's difficulties sleeping problems and her anxiety complaints, even the simplest methods proved to be sufficient: she developed an evening routine that included logging her feelings and thoughts, sipping her favorite stress-relieving herbal tea, refreshing her old-fashioned autogenic training, refreshing her memories. We also included some simple breathing and relaxation exercises in our self-reassuring techniques (abdominal breathing, complete yoga breathing, progressive muscle relaxation, conscious walking).

I only had meetings with Maria nine times. These occasions assisted her to become much calmer, more optimistic, more balanced, looking forward the IVF program with excitement, surrounded by helpers she trusts. She no longer sees the process as something devilish, but as an opportunity that will help her become a mother.

In the case of patients with endometriosis and fertility disorders, it is often necessary to have a systemic approach, in which the involvement of the family and the couple becomes necessary. For one of the nine meetings, I also invited her husband, Peter, to assess the extent of his support as a partner and the dynamics of their relationship.

He gladly accepted my invitation because he also had some questions about IVF, he was afraid of the effect this procedure could have on his wife. He was reassured when he received the necessary information that he had lacked, so education and information transfer played a key role here as well. I have witnessed Maria dare and be able to talk to her husband about her feelings about IVF. She found a good partner in Peter, I have confirmed to them what a good team they are.

The PRISM-D drawing test of the client is attached. The advantage of the PRISM-D drawing test is that it can be used quickly and easily to map the client's disease representation and coping factors. Visual representation of the current life situation expects activity from the client, facilitates conversation with the support staff, and helps to look at the current situation more easily, self-reflection. The test recording can be repeated several times so that we can track the changes and the progress (Havancsák et al., 2013).

The drawing shows a so-called self-shield constellation, things important to the person surrounding the self. The function of the self-shield is most often to "protect" one from the disease, but here this function cannot be asserted, since Maria depicts the disease, endometriosis, in the form of a uterus and ovary, as a "self".

It is important to point out that Maria separates herself from her surroundings with several intersecting, thicker lines, marking some extra protection, extra detachment from her surroundings. The husband, two girlfriends, Maria's mother and father, and two pet dogs are depicted close together as part of the "self-shield". All this is concentrated in a small size in the lower right corner of the page, the page is almost empty, there are job, doctors, and doing sport in the corners. Halfway between the doctors and job, she placed the IVF in a rectangle, expressing that the it was somehow separated, as she said, "it doesn't fit in the picture."

After talking about the drawing, Mara herself initiated that she wanted to "redraw" to show what her ideal layout would be, which would reveal the desired situation. In this second drawing, the self is only a circle surrounded by an outline, the disease is further away in the form of a circle, and the self is not affected by anyone, nothing. Relevant people were given more, breezier space to "move more easily if I wanted to," Maria explained. The test-tube got closer and got a circle shape, the doctors got a smaller circle next to the tube. Job and sport circles remained unchanged. Overall, the image shows a much busier, fuller, more harmonious layout. I asked her what was needed to have it realized, and Maria herself provided solutions: talk more openly with her parents, trust her partner more, be more accepting of the test-tube and the doctors. I gave positive feedback on this action plan, as she formulated her own goals and opportunities for the near future, which increased her motivation, commitment and sense of control.

2.5. THE CLOSURE OF THE CASE

Maria's relationship towards herself also changed a lot. As she was able to open up more and more to his partner and firmly trust her doctor who looked at her as a partner, as well as our relationship, she began to become more and more tolerant and accepting her own self. At the end of the last meeting she said that she did not think she should be blamed for her illness, which is the reason of her fertility problems. She sees her own body as a partner who will help her to become a mother, a partner in achieving this goal, and she will be happy to receive the medical help she needs towards that goal.

The client gave a high score on guilt questions in the first interview on the Beck Depression Questionnaire (Beck et al., 1961) (I constantly blame myself. I deserved the punishment.). These feelings were dissolved at the end of the work. The original score (14 points, moderately severe) improved significantly compared to the condition recorded in the first interview (6 points, the lower limit of the mild state) by the end of the process.

An important result is that by the end of working together, the couple will no longer see their marriage as shattered by the difficulties of having children, and they can even imagine that they will get even closer together and deepen their relationship by overcoming the obstacles together. This shows the potential for post-traumatic development.

Maria was able to overcome her negative experiences and put her confidence into a team to help her. At our closing consultation, she said goodbye to me: "As much as I was afraid of IVF, now I find myself looking forward to it… I'm open to good things finally happening to us."

3. CONCLUSION

Based on the reviewed research findings and the case study described, it is clear that the treatment of endometriosis necessitated an integrated approach that recognizes the role of psychological factors. In this, adequate knowledge of the psychological aspects of treatment can be expected from all members of the healthcare professional. Extra attention should be paid to make sure that women do not feel marginalized and see their concerns belittled. They need medical staff to acknowledge the reality of their concerns, and both reassurance and information play a major role in this (Slade & Cordle, 2005) In the title of his study, Lachowsky (2012) goes as far as to ask the question: who should treat a patient with endometriosis: a gynecologist, a doctor, or a psychologist? Physical and psychic pains – even if they don't add up – are mutually reinforcing, especially when the past is overshadowed by other difficult life events. For many years, women with endometriosis have found themselves branded neurotic, hysterical, not treated as "real" patients, denying the reality and significance of their now-recognized pain. A breach of human dignity can be healed if medical staff recognizes and acknowledges the difficulties associated with the condition, treating patients in a multidisciplinary approach. While writing this chapter and practicing my profession, one of my main goals has been to achieve the team work of professionals of different disciplines to work as a team for the health, present, and future well-being of patients.

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Part 4

SURGICAL AND INVASIVE CARE

Petra Pócza-Véger

HEALTH PSYCHOLOGICAL ASPECTS OF PAIN. THE RELATIONSHIP BETWEEN EARLY TRAUMATIC EXPERIENCES AND COPING WITH CHRONIC PAIN

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Pain is the most common complaint people would see a doctor about (Komoly & Palkovits, 2018). In order to understand the complex experience of pain, besides psychological theories, it is also important to understand what happens on the biological level when someone is experiencing pain. The book chapter attempts to integrate psychological theories and research findings that use imaging techniques to help this understanding. Based on these, we connect the experience of chronic pain to early, traumatic experiences, as the sensitivity of the nervous system can be suspected as the reason for both of them.

1. LITERATURE REVIEW

Pain information reaches the central nervous system via the following areas: the ascending pathways of the spinal cord first reach the brainstem, where they switch primarily in the rostral ventromedial part of the spinal cord, the parabrachial nuclei of the bridge, and the periaqueductal gray in the midbrain. The next important switch is in the thalamus, where pain information separates into two further pathways: the lateral tract travels to the somatosensory areas, where the intensity and localization of pain are realized and evaluated, while the medial tract includes the anterior cingulate cortex, the insula and the orbitofrontal cortex, which are responsible for the development of pain-related emotional, motivational and behavioral responses (Köteles, 2013).

Birbaumer and Flor (1995) demonstrated that people living with chronic back pain responded more intensely to the same pain stimulus than healthy control subjects. In their research, they examined brain activity related to painful stimuli with an EEG device. It is possible that those with chronic pain responded more intensely because frequently used neural networks fire more easily and more intensely (Bauer, 2011). In addition, we suspect difficulty in emotion regulation in chronic pain, the treatment of which is as important as the biological aspects of pain (Kökönyei, 2008). Chronic pain might be considered a condition that shakes self-identity (Chapman &

Nakamura, 1999), so for improvement, it is essential to understand and support that psychologically. According to Kökönyei (2008), chronic pain can be considered a traumatic experience in itself, as it is a phenomenon that continuously affects everyday activities, anticipating physical damage.

In case of a severe trauma or violent events, especially when they happen in childhood, dissociation can occur as a psychological and neurobiological defense mechanism designed to make the unbearable bearable, to turn off the physical and emotional pain experience. Psychologically, as a result of dissociation, the person also moves away from the present, from their own sensations and perceptions. The production of endorphins increases as we experience pain, and during dissociation (Zubieta et al., 2001), as the body helps to bear the unbearable. This mechanism can attenuate mostly the emotional part of pain as endorphin production increases the most in areas of the brain that process the emotional aspect of pain (gyrus cinguli and amygdala). Thus, dissociation also occurs at the biological level, with the registration of self-sensation and physical pain being separated (Bauer, 2011).

Porges (2004) believes that neuroception is the neural process by which a person unconsciously evaluates whether the environment is safe for them, or on the contrary, it is actually dangerous. From a health psychological perspective, this could be interpreted as the patient giving meaning to the environment and what help they may expect from it. In the clinical environment, it can often be observed that patients do not feel the environment distinctly safe. According to Porges (2004), a safe environment results in a physiological state (e.g., low heart rate, accelerated metabolism) that can help rebuild the body, facilitate relaxation and self-soothing, and besides, create social bonds. The latter is an important part of coping with illness and pain from a health psychological perspective. For this reason, when working bedside it is important to understand that the patient may even see the medical staff as a threat, especially in the case of comorbid psychiatric disorders.

2. CASE DISCUSSION

In this section, we describe a case that well illustrates the theoretical background presented above. The patient gave his consent to present our work with him in a scientific or educational environment. The young male patient (33) had already undergone surgery twice for lumbar spine problems (after which massive inflammatory problems also slowed the recovery) when he was admitted once again to the neurosurgery ward, scheduled for spinal surgery. After surgery, he was admitted to a sub-intensive care unit, when the nurses notified me, a health psychologist working in the ward, that they feel the patient might also need psychological support to make his recovery smoother.

The patient was literally wailing with pain and seemed to disturb the other patients in the room. Despite his pain he readily accepted the psychological help, his pain fluctuated in my presence. Occasionally, his symptom-presentation made a theatrical impression, but in a couple of minutes his attention could be easily steered away, and as if the pain would subside significantly, his face got relaxed too. The patient was convinced that the severe post-surgical pain was caused by thrombosis, because his left leg was swollen, and he experienced a burning sensation (the meeting took place during the COVID-19 pandemic). At this point I could only connect to him through the pain, I hardly obtained any other information, almost as if only the pain existed. It was like even the quality of our connection was determined by the pain. When the pain got more severe, the connection felt distant, only when I succeeded to deter his attention from pain did I feel that I could truly connect with him.

It was sensible that receiving attention and care relieved his tension, and in turn this eased his pain. Him being continuously on infusion (receiving painkillers, antibiotics) gave me an opportunity to facilitate pain relief with the use of positive suggestions. By addressing his worries about the thrombosis (I notified the staff, and a doctor also examined him), the patient also gained a sense of control over the situation, which helped alleviate the pain, at least temporarily.

The patient has an office job and lives with his wife and three children, whom he has not been able to see because hospitals banned visits due to the epidemic situation. This made things difficult for him, keeping in touch on the phone only. He has been missing his family. It was clear, and the patient told me so, that his family provided one of the most important resources for him, giving a purpose to even these difficult times.

By the second session, he was back in his room, his condition did not require strict medical supervision. However, the post-surgical MRI scan revealed that one of the screws was not in the right position, thus corrective surgery would be needed. This explained the patient's severe pain after the surgery. The patient received the news with a bit of resignation. “It does not matter, just make the pain go away” he said laconically. His pain, compared to the post-surgical pain, was milder, more bearable, but he also received strong painkillers. At this session, without me specifically asking, he shared that he was a child, only 4 years old when he had lost his mother, by homicide. (It is hard to decide in situations like this, whether it is worth exploring the trauma, especially in this phase of somatic healing in a 5-bed hospital room.) The information was overwhelming, as it was stated so abruptly, unexpectedly, probably facilitated by the regressive state of the patient (because of pain, he was mostly lying in bed). I did not go into the details of his trauma, I thought that at this phase the emotional burden of this very significant life-event would not support the somatic healing process. But I did ask why it became suddenly important. Why did it come into his mind? So that I would see how hard his life had been, he answered. It seemed that this traumatic life event had also become identity-forming to him. In this session, several things can be demonstrated that were discussed in the theoretic part. We are seeing a passive attitude to pain, a lack of agency, which could be condensed in the patient's life, especially the early, traumatic loss of his mother, and its circumstances. Just as he could not do anything to save his mother as a child, the pain was also something just to endure, to bear, just hoping it would pass. As if his freezing, his emotional numbness has become a coping mechanism at a neurological level, and in the clinical environment the pain and the regressive state have brought it back.

The third session was mostly about the patient getting ready for the corrective surgery the following day. His thoughts were focused on that, so I also tried to prepare him psychologically, although he was not visibly anxious about the surgery. Rather, he had a positive attitude towards it, expecting it to end his pain. He trusted his doctor all along, the enthusiasm and respect he showed for him seemed almost exaggerated. The doctor might have appeared as a good, reliable, safe father figure that, as it turned out later, such a figure was missing completely from the patient's life. This process of positive transference might also have been supported by the doctor's age.

The fourth session happened after surgery, the patient was seeing me relieved and in less pain. His tone was more informal, and he constantly included his roommates into the conversation. Now that the pain became bearable, he visibly struggled to inhibit his impulses, although his difficulty of inhibition was familiar from previous instances of pain. He told me how disturbing other patients were in the sub-intensive unit (without realizing he could also be of disturbance to others), and if he could have left the bed, he would have hit one of his roommates for being so annoying. When I further inquired about this, I learned that he already had a confrontation with the law. I had the feeling that he did not sense the weight of it, as if he would only show off. The intention behind this behavior probably was to influence the other male patients in the room, and the unconscious goal to impress me as well. I felt aggression is present in his connection to his environment, even if only implicitly, at the level of fantasies. This aggression must have been there in his life from early childhood, as he lost his mother to an aggressive act. In a sense, the surgery can be seen as such a process, where the patient's body becomes vulnerable as well.

At this point, it is worth to recall Bauer's (2011) idea from the introduction that dissociation can take the form of freezing and that of impulsive acts. Here, in some respect, both could be observed on the patient. He froze when the pain was intense, passively trying to endure, to bear it. However, when he got better, the more aggressive impulses appeared, both verbally and at the level of fantasy.

At the fifth session, it was much easier to steer his thoughts a bit towards the future and talk about how he planned the period after the discharge and his recovery. As it turned out that previously, following his surgeries he did not take time to rest, we took more time to talk this through, that it was worth changing his strategy, as it was not helping his recovery process. I felt that after four surgeries he understands it better, but his acceptance may have been also motivated by a desire to meet my expectations. In any case, he was planning a gradual return to work, which his workplace could probably support. At this meeting, he told me that his uncle had died recently, to whom he looked up greatly like one does at one's father. Sadness, however, did not appear on his face.

By the sixth appointment, we were able to leave the room and we had a conversation while walking outside the ward, stopping whenever the patient's physical condition made it necessary. We did not sit down, however, because after spinal surgery it is not medically recommended for the patient to sit for a longer time. As it gave us a chance to talk alone, I asked him about his mother's death. With no roommates around, the sadness on his face was much more apparent, and he said in a childish way that he has been missing her very much. After the death of his mother, his father started to drink, "went on a spree", he said, so he could not rely on him either, there was no one to learn the rules and customs from. This is how his uncle, who was reliable, had become a father-substitute for him, and became an important presence in his life. He told me he was glad that I came to see him over and over because he felt that "something was not quite right in his head", but when I asked him about it, he could not give me any exact details on what he meant. He was happy about the improvement of his condition, although he was still walking with an aid. As he was to be discharged the following day, we said our goodbyes, ending our work together.

The lack of a father seemed to be somewhat mitigated by his relationship with the uncle, and a secure, supportive connection was able to develop with him in the patient's childhood. The role of the older, protective male has also appeared in his relationship with the doctor, it became idealized, and this was matched with the fantasy that the doctor would save him from suffering as the uncle had done in his childhood.

Lessons learnt from this case

First of all, that personal presence is a vast, supportive power in bedside work in health psychology. Often, during supportive conversations in the hospital rooms, very deep losses and pains emerge, which cannot be resolved or explored in the given setting. Often it is only possible to substitute the missing, reassuring, safety-giving self object, the internalization of which had not happened due to early traumatization/injury. In such cases, it is important to contain the (physical and emotional) pain that may not be bearable for the patient alone.

3. DISCUSSION

By writing this chapter, I have tried to bring together those clinical experiences, aspects, research and scientific findings that allow a better understanding of the phenomenon of pain. I also found it important to integrate knowledge from different disciplines, which could be useful for the better treatment of patients with chronic pain. The topic of pain in clinical practice is still often viewed in a dualistic way: if there is an underlying organic reason for the pain, it is considered a medical issue, if it is missing or difficult to verify, it is treated as a psychological/psychiatric problem. The results and experiences discussed above, as well as the brief presentation of the case, show that this dichotomy does not help patients to heal, to improve their condition since the experience of pain is a complex phenomenon and both its over-biologicalisation and its over-psychologicalisation are likely to distance us from true understanding.

Perhaps the most helpful approach to treating pain is to provide the patient with the knowledge of several co-disciplines with opportunities offered by teamwork.

In the daily routine of a neurosurgery department, this is accomplished by involving a nurse, physiotherapist, pharmacist and health psychologist in the healing process alongside the work of the doctor, and in this way, it is possible to integrate different perspectives that may not be apparent to a single specialist.

In understanding chronic pain and the possibilities of positively coping with it, we find cognitive neuroscience research to be of great importance, as it allows us to better understand why certain patients react to pain passively and helplessly, while others are more able to help their own recovery by active coping. As we have seen at the case presentation, at the beginning the patient was only able to passively suffer from his pain, which could have been activated by the early traumatization experience stored at the neurological level. To help his impaired self-regulation we tried to support him from outside, to control the pain and impulses (painkillers, positive suggestion, containment) which from the inside was impossible or very hard for the patient alone. Giving meaning collectively advanced the process of coping with the pain. The patient surrendered to the pain, as helplessly as he had surrendered to the childhood loss, and initially felt he had no control over the pain.

The importance of the early relationships is also notable, because patients who suffered an early psychological trauma present their pain in a harder-to-understand way to the people around them, often elicit reactions of negative countertransference from their surroundings, which correspond to the traumatizing early environment, thus the trauma may also be repeated. By his behavior and metacommunication, the patient may make the members of the medical staff react similarly to someone from the past (Gabbard & Lester, 1995).

It's important to help patients with what they need, not trying to convince them that their coping mechanisms are failing. Often, psychoeducation can be useful and supportive for the patients, however, explaining why they might find it difficult to experience pain does not always help because in the case of childhood trauma, experiencing pain is damaged at the neurological level and embedded within a relationship. Thus only through the relationship, by altering the implicit representations can we achieve long-term success. Sadly, mostly only the outpatient care provides the opportunity and the appropriate, safe framework for this. As health psychologists, the most important thing we can help patients with is to provide a safe space and background for their recovery.

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BODY IMAGE AND SELF-IMAGE CHANGES AFTER SURGERY. HEALTH PSYCHOLOGY INTERVENTION FOR WOMEN RECOVERING FROM MALIGNANT BREAST TUMOR

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Modern medicine has brought major technological advancements, which caused the wholistic approach to lose ground, and because of the high patient turnover, establishing a good doctor-patient relationship became more difficult (Kabaa & Sooriakumaran, 2007). Surgery entails considerable passivity for the patient, which can hinder successful recovery in its later stages, as patients are often unable to step out of the helpless patient role. With the exploding advances in technology, the surgical treatment of breast cancer has also changed, with the early radical, mutilating procedures being replaced by modern breast-conserving surgery (Mátrai et al., 2015). Currently, modern breast surgery is characterized by oncoplastic operations and advanced reconstructive procedures, which can lead to better aesthetic results and faster physical recovery. In many cases, however, the psychological recovery is much slower and it is not uncommon that the psychological apparatus is unable to catch up with the drastic and rapid physical changes. The messages conveyed by modern medicine can give the illusion that in a matter of moments, we can easily reorganize ourselves (Foucault, 2000), although this process can become psychologically problematic. After all, changes in body image due to physical and/or mental trauma cannot be processed from one moment to the next. Although a 1993 study (Schag et al., 1993) showed less distress in those breast tumor patients who had better cosmetic outcomes, i.e., after surgery they have undergone plastic surgery too, in a longitudinal study design the data could not be reproduced, there was no difference between the two groups in the long term (Al-Ghazal et al., 1999). The psychological balance after surgery is therefore not only dependent on the surgical procedure, but is also influenced by the patient's expectations, representations of the disease, coping strategies, impairment of body image, and the extent to which the person can accept and reintegrate the new situation into his/her previous life (Broadbent et al., 2004; Csabai & Molnár, 1999).

1. BODY IMAGE CHANGES AFTER SURGERY

The rate of negative body image and body dissatisfaction due to physical, intrapsychic and interpersonal processes increases dramatically in patients who have undergone surgery. Numerous studies have documented adverse body image and psychological distress, feelings of disfigurement, and loss of femininity in women who have undergone surgery for breast cancer (Donovan-Kicken & Caughlin, 2011; Fairburn et al., 2018; Falk Dahl et al., 2010; Hopwood et al., 2010).

The success of recovery, as also suggested by research findings, strongly depends on the patient's body image impairment (Grogan & Mechan, 2017). According to Collins and colleagues (2018), poor quality of life after mastectomy was mainly associated with damage to body image and femininity.

Surprisingly, among the women who have recovered from malignant breast tumor, those who also underwent breast reconstruction surgery, had a significantly more negative body image than those who did not undergo plastic surgery. However, other studies imply that patients, who underwent reconstruction surgery after mastectomy, rated their quality of life higher and although their self-esteem had not changed significantly, they felt more attractive, “whole again, that there is no need to feel ashamed of their body”, in contrast to those women who did not choose plastic surgery after mastectomy (Tykkä et al., 2002). Another study demonstrated that patients who waited more than a year for reconstructive surgery reported fewer psychological problems than women who received implants within a year (Schain et al., 1985). A detailed analysis of the data reveals that psychological status is roughly similar when the two types of intervention are performed in a single treatment (tumor removal and reconstruction are simultaneous) and when patients wait for longer (more than a year) for plastic surgery. Women who had implants within a year were the worst off and had the most psychological problems. A mastectomy seriously disrupts a person's bodily integrity, and it can take up to a year to accept the altered body image (Taylor, 1983). If losing one or even both breasts and the reconstruction happens within a year, it may require such a high level of psychological work that it could overwhelm the psychological apparatus. Both clinical experience and research (Izydorczyk et al., 2018) have shown that patients who have undergone breast cancer surgery should be offered the opportunity to receive professional psychological support as soon as possible, ideally after surgery, when they are less able to deal with negative emotions.

2. CASE STUDY

I have been working with patients with serious physical illnesses requiring surgical care for over ten years. I am always moved by the immense strength I see in them. Fortunately, our profession is getting closer to them, they are becoming increasingly open to psychological help and are interested in the psychological factors that facilitate recovery. Many of them have abandoned the frequently occurring attitude of "I am not mad, why would I need a psychologist", although many times there is still a – justifiable – sense of confusion: "how is this going to help me when I have a tangible, physical illness?" Therefore, the empathy of the healing professionals and their attitude towards recovery are of particular relevance. Dóra's story enables us a look into the difficulties of recovery after breast surgery and the possibilities of health psychological intervention.

Dóra appeared to be a desperate, broken woman. The first time we met, Dóra behaved in a reserved manner, not returning my smile in the waiting room. I walked her into the counseling room. She sat down before looking around, and said, matter-of-factly: *"I have cancer and I think I'm depressed",* then went on to give a lengthy, detailed history of her illness, from the appearance of first symptoms (breast defluxion), getting a diagnosis (precancerous cells were found), waiting for surgery: all without any self-reference or expressing emotions. Her left breast was removed over a year and after a couple of months, she received an implant. The aesthetic correction of the other breast is due in the coming weeks. Dóra was visibly locked into her disease, and as a result I had to work for the two of us for a a period of time.

Holding a university degree, she worked in a top position in the financial sector. She used to love her work, but after the diagnosis, she has found joy in it no longer. As it turned out later, she experienced a great amount of stress and anxiety because of her workplace and deadlines. She is approaching forty, lives with her husband and their two boys. She plans a lot of activities with her family because she feels that being distracted helps. She used to love reading, gardening, baking, and any activity that allowed her to be alone (or rather, by herself). *"I would still love to, but I do not have the time."* The quality of her sleep is particularly poor, she wakes up at dawn and can't go back to sleep. She does see some connection between events in her life and her symptoms, but when I ask her what would be her goal, she mentions stress management and *"being more decisive, I don't really know".* Inevitably a smile appeared on my face, which Dóra returned with a laugh. I felt confident about establishing a good therapeutic relationship. We contracted for 15 sessions, with the aim of working with the disease, recovery, and related factors. During the first sessions, we took the PRISM-D nonverbal drawing test developed and validated by our research team (Sándor et al., 2020), which could also help us to detect the impact of the disease and potential resources. Now I would refrain from presenting the test, but perhaps the blinding whiteness of Dóra's drawing test is still striking (Figure 1). She has left much of the life-area empty, but the disease (red circle) occupies a central place, almost enveloping the self (yellow circle).

She sees her husband and their marriage realistically. There are disagreements (mainly over the household), but they soon get over them. Dóra is slow to open up, talking shyly about the relationship difficulties caused by the illness and treatments. Her body image has never been very positive, but the losses and body asymmetry caused by surgical treatments have torn her self-confidence apart even more. She is reluctant to look in the mirror, finds it difficult to touch her own body, and has lost confidence in it: "How can I trust my own body again when it has let me down like this?" Choosing the right therapeutic tool is key to fostering a trusting attitude towards your own body. Projective assessment tools that provide a deeper insight into the patient's emotional world are an excellent way to examine the damage to body image and self-image. In Dóra's case, instead of a classic human drawing, we worked with a pre-printed human figure (in my experience, some clients prefer this over receiving a blank sheet) and asked her to complete the template by drawing herself on it. Dóra's image (with her permission) is shown in Figure 2. As she looked at her drawing, she became increasingly aware of the complete absence of feminine gender features in the picture. Then her relationship to her own femininity and her own body came into focus. Although we did not apply it to Dóra at the time, in many cases the body-image-sculpture test is helpful in facilitating a deeper bodily experience and mitigate the damage to the wholeness of bodily experience (Fehér & Kecskés, 2011).

Dóra's depression appeared to be moderate and she refused any possible help of medication. For a while, she seemed completely resistant, but I tried to stay patient. A dynamic appeared: when she comes, she feels fine for a few days afterward, but the effect is not long-lasting. We were halfway through the agreed therapy sessions and I felt we were marking time when the ice finally broke. Dóra experienced a really bad weekend: *"I was annoyed with my husband, the kids, cooking, work, everything, and I don't know why".* When we took a closer look at the situation, the feelings, the real cause of her annoyance, *"I don't know"* suddenly made sense. She cried. *"The illness, still... "*During the remaining time of the session Dóra framed some difficult questions. *"What is the meaning of illness? Why did it come at that particular time? How was my life then? How did I get here?"* An inner work would begin, which eased the grip of depression week by week and her sleep improved. In the evenings she started to write in her diary, so instead of suppressing the feelings, she tried to write out the distressing, painful memories and physical sensations associated with the illness. We are familiar with Pennebaker's (1997) research on the beneficial physical and psychological effects of writing, and we observed these here as well.

We used several projective techniques to better understand the often unspeakable underlying feelings and thoughts. I asked her to draw a picture of her illness (Figure 3), which she found to be a very difficult task. Remember that at the beginning of our work, Dóra spoke without emotions about the trauma she had suffered, the pain caused by the illness and the treatments. After much contemplation, she took a black marker and drew a cell growth covering the breast. When I asked her what could help the disease go away, she thought some more and then drew a sun *"to be enlightened"* and a human brain *"to accept it". "It will probably stay with me for the rest of my life... (crying) I'm sick."* she said. What happened next still moves me to this day. For a while, we looked silently either at each other or at the table while Dóra cried. It was an exceptionally intimate moment that banished all uncertainty. This is how Dóra started the first session: "I have cancer and I think I'm depressed" – as if she was telling me that she had to work tomorrow. Now she said, "I am sick." We both felt the real weight of that sentence. The fear and pain became almost tangible, the words and feelings became one and we understood the real cause of the problem. What Dóra is really afraid of is the unpredictable, unknown future. How can we change this? We cannot. The future remains unknown and unpredictable. This is not the answer Dóra was looking for, but what we can change is our attitude to illness. Dóra's doctors are very positive about the future, she has been declared cured, she doesn't need check-ups, her treatments have been completed for a year now, and although she has understood this on a cognitive level, it seems that her psyche has not been able to follow these drastic changes.

During the following sessions, we talked about her relation to the illness (How does she think about her illness now?) and her perception of health (What does health mean to her?) Dóra's body has been the scene of dramatic events, the trauma of the illness has torn her life and her representations of it apart. Although visible to me, it was very difficult to grasp the insecurity and the sense of inner emptiness that Dóra was going through. Yet when she did and faced them with enough courage, the negative feelings suddenly began to diminish. The anxiety caused by the burden of a serious illness eventually triggered a radical personality change. She examined her own role in the development of the disease and took a more active, responsible approach toward her health. This was perhaps the turning point, as one of the fundamental problems in treating patients with cancer is the helplessness and the loss of control. We are responsible for the attitudes we hold when facing our problems – our illness, in this case – which can help us at any stage of the disease, increasing our sense of power and control (Yalom, 2019). Raising awareness of responsibility, however, is not an easy task, the therapist soon stumbles upon an uninvited guest: guilt, the dark shadow of responsibility. Before we dive into the most important insights of existential psychotherapy, let us return to Dóra, who, after realizing her own responsibility, set out on a path to personal fulfillment. She is aware that the disease may recur, but her life is no longer ruled by paralyzing fear. The unconscious vegetative reactions have subsided and the negative experiences caused by the disease have been smoothly integrated into the life story. She feels alive, she is trying to have the best possible relationship with her husband and children, she has started to eat healthier, exercise more, and now she is not going "crazy" about work, because she feels in charge and although she cannot control everything, she is doing what she can to stay healthy and balanced.

3. DISCUSSION

3.1. THE TRAUMATIC LOSS OF SELF

We should always pay close attention to the first sentences, as they often predict the success of the therapy. Yet as professionals, we should not allow ourselves to be led down the wrong path, getting stuck in words and phrases, such as a detailed description of the treatment process. Often this is the first step of self-disclosure, when the patient talks about her physical complaints, where at the most impersonal level the client is hardly involved in what she is saying, only talking about external events and other people. Let's be patient, it can be a long process before the patient is able to deal with her own inner experiences in an in-depth and differentiated way, and then to change her behavior based on her insights (Tringer, 2007).

Numerous papers deal with reactions to trauma, but we do not know exactly what conscious or unconscious, explicit or implicit processes facilitate the healing process. We do know that a diagnosis of a serious illness brings about changes in the patient's perception, physical experience, and imagination. The patient may often obsessively return to the past, to the moment when she last experienced intense involvement and deep negative feelings: the events surrounding the diagnosis and the surgery. But without mental flexibility and imagination, there is no hope, no possibility to project a hopeful, optimistic future worth living and fighting for (Stupiggia, 2016).

While telling the history of the illness, the empathy and unconditional acceptance of the psychologist helps to build rapport, but in many cases, giving a detailed story is not always helpful even in a therapeutic context. It does not bring relief, because there is a pain we cannot talk about, and instead, we risk getting traumatized again. Actually/In reality, we have no words to describe what happened, because the presence of trauma takes away the relief of the narrative. Of course, we might come up with some kind of a story to hide behind it, but instead of a coherent narrative of emotional charge and experience, we see reactions at the physical level (Stupiggia, 2016). Therefore, verbal therapy techniques alone will not work, and we can also reach a dead end if the treatment is too focused on the body. For example, relaxation techniques can cause passivity, which can induce the helplessness the patient have experienced during surgical and oncology treatments.

3.2. HOW CAN I TRUST MY OWN BODY AGAIN?

Most patients facing a serious physical illness tell us that they experience deep and painful insecurities about their own bodies. Usually, after successfully coping with the illness, in the final phase of recovery, patients anxiously ask the question, “How can I trust my body again?” Frequently, the highly anticipated relief would not arrive even after the patient (physically, according to the doctors) has recovered. At any stage of coping with the illness, this feeling is a huge challenge for us, health psychologists. How can we help the client to regain or build up a trusting attitude towards their own body? The history of the illness and the life story aside, we also include bodily experiences and communication with the body in the therapeutic work. Our body image, our relationship to our body, is such a deeply personal experience that we cannot express it only verbally. Trauma is much more than an event from the past: it leaves a mark on both the body and the mind. Whether it happened a few days or several decades ago, clients are unable to bridge the gap between the current life situation and the traumatic life event, since only that event which caused them so much pain has meaning for them (Tedeschi & Calhoun, 2004; van der Kolk, 2020). Although it matters a lot if patients are supported in putting into words what has happened to them, this is usually not enough for full recovery, as the body still reacts with the same physical and hormonal responses as if the trauma would happen now, in the present. In facilitating healing, we therefore need to override the body's automatic responses, accept on a physical level that the threat is in the past and then learn to live in the present.

Gentle physical interventions can be suggested, in which we work with bodily sensations to restore a positive attitude towards one’s own body. Gradually, attention is directed more and more inwards, towards the inside of the body. The accepting attention to bodily sensations, learning to exist in the present and to focus attention holds a lot of potential (Szondy, 2012). Observing bodily conditions and monitoring breathing alone (without regulation or any action to do so) can lead to the elimination of emotional distress (Perczel-Forintos, 2011). However, in many cases, the damage caused to the body image damage is difficult to grasp, as the feelings and experiences associated with it often dissipate before reaching a conscious level. The body always “knows more” than we do, it both senses and is sensed; it is through my body that I grasp the outside world (Merleau-Ponty, 2006). Body image can become a map of the traumas experienced, if the unity of bodily experience, the wholeness of the body is violated, leading to a fragmented body, a splitting of body parts (Geerardyn & Walleghem 2005). This can lead to the patient not being able to touch the affected body part or the site of the operation (for example, their stoma or the scar on their chest after a mastectomy). Fortunately, we now have non-verbal therapeutic and diagnostic tools that reveal bodily experiences, such as the body image-sculpture test (Fehér & Kecskés, 2011) or projective drawing tests (Machover, 1951; Witkin, 1962), which can be used to assess the degree of self-integrity and self-constancy and help to ensure the success of the healing process. According to our most recent knowledge, the best way to assess illness perception and psychological conflict is to use projective drawing tests (Broadbent et al., 2006), which can also be used to examine self-image and body image, self-energy, coping mechanisms and traumas (Vass, 2011).

That the somatic, bodily representations of memories are projected onto the drawing has been explored by several research groups, as they are not only a reflection of the psychological state, but also of the success of recovery. In cardiology patients, drawing an injury on the heart was not only associated with increased depression and a more negative attitude towards the disease, but clinical data (sodium levels, BNP = confirmed neurohumoral activation) also correlated with characteristics of the drawing test. And the damage drawn on the heart was a better predictor of the patient's recovery than any other medical indicator (Broadbent et al., 2004; Petrie & Weinman, 2012; Reynolds et al., 2007). Our research with transplant patients has shown that in anxious patients, mental representations of the organ are overemphasized, which on one hand prevents normal intrapsychic integration of the organ, on the other is associated with kidney function values and may predict the success of the transplantation (Látos et al., 2021).

The PRISM-D non-verbal drawing test can also be helpful, not only as a research tool but as an integral part of the intervention (Sándor et al., 2020). In Dóra's drawing test, the disease surrounds, or we could say absorbs, the self. The results of our own study together with the findings of other research groups confirm that the larger the subjective image of the disease, the more pronounced the anxiety associated with the disease (Petrie & Weinman, 2012; Sándor et al., 2020). Using drawing tests, we can develop an innovative technique to obtain a more accurate picture of patients' attitudes and beliefs about illness that are predictive of recovery and survival. Drawings are also more effective than verbal questionnaires in assessing the effectiveness of therapies (Horwitz et al., 2006), therefore in many cases a PRISM-D drawing test is administered again during mid-therapy or later.

3.3. THERAPEUTIC GOALS AND POSSIBILITIES: COHERENT SELF AND POSITIVE BODY IMAGE

Psychological support before and after breast surgery, which helps the patient to accept the emerging feelings and the new life situation, can also greatly assist the recovery process (McGregor & Antoni, 2009). With psychological interventions, patient cooperation and satisfaction can also be positively influenced. Patients are more likely to follow the doctor's instructions, take their medication accurately and do not miss follow-up visits, which is confirmed by clinical experience and research (Andersen, 2002; Kahana et al., 2008).

In restoring body image and self-image, besides body awareness, there is a strong emphasis on relational work. In health psychology interventions with patients with serious illnesses, even those requiring surgical intervention, we need to give clients the opportunity to express any negative feelings and concerns they may have about their health and their own body. They may show frustration, anger or envy towards others who are healthy. We also need to give room to future expectations, fears and anxieties about possible changes in social relationships. It is the task of the professional to unconditionally accept the patient's experiences, fostering a coherent self (Rogers, 2008). Over time, the client introjects the attitude of the helper, so that the previously threatening, negative feelings become acceptable and part of the self. Through the integration of new experiences, the individuals learn to know themself in a more complex way, the body image is reconstructed and the previous structure of the self is modified. Another key factor in recovery is that as health psychologists, we do not ally ourselves with symptomatic behavior, but with the patient's best interests, with the self that is healthy and wishes to heal. If the patient takes an active role in their recovery, changes his or her lifestyle, participates in rehabilitation, follows medical advice, etc., they can regain control of their illness and their life, which can result in more balanced psychological functioning.

Lessons learnt from this case

It is inevitable that when clients are struggling with physical illness, working with the body is present in therapeutic work. Any treatment using nothing but verbal methods is almost certainly bound to fail. It becomes difficult for the patient to experience their self-identity as the mutilated body and the psychological problems it causes are only a distant reminder of the person's former self. The damage to the body, the surgical scar, heals relatively quickly, but the damage to the body image and the trauma caused by the illness heal more slowly. Therefore, a well-designed health psychological intervention is of great importance, to help repair the damage to self-image and body image, reduce existing depression, anxiety, and negative attitudes associated with illness. It may improve the patient's quality of life and change health behavior for the better.

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Figure 1. PRISM-D nonverbal drawing test, the yellow circle represents the Self, the white sheet of paper the client's life-area, where she drew her illness first, then important persons and activities, each represented with a circle.

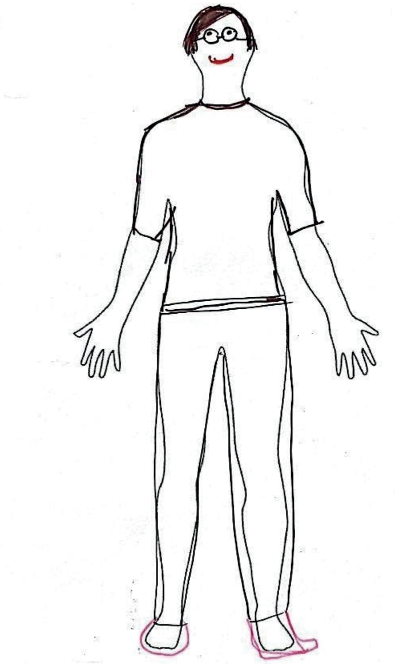

Figure 2. Dóra's own picture of herself.

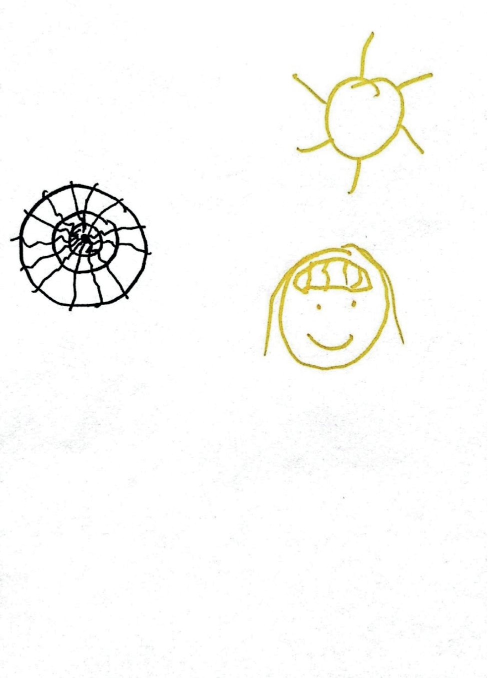

Figure 3. Drawing about the illness and the factors promoting recovery.

Zsófia Ocsovszky and LillaTusor

PSYCHOLOGISTS IN THE INVASIVE CARDIOLOGY CARE

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1. INTRODUCTION

Although there has been a significant decline in the aggreavated figure of cardiovascular disease mortality in the past few decades, ischemic diseases (IHD – ischemic heart disease) are still one of the leading causes of death for both sexes worldwide.

The etiology of cardiovascular diseases (CVDs) has already been investigated from numerous aspects, thus we have extensive literature to rely on. Traditional physical risk factors – such as hypertension, diabetes, high cholesterol and obesity – do not fully account for the development of cardiovascular diseases. According to data in literature, patients develop at least one of the so-called 'traditional' risk factors. Psychosocial factors are estimated to contribute 25% to 40 % to the development of coronary heart diseases (CHD) (Strike & Steptoe, 2004). The damage of health occurs due to behaviours effecting health harmfully. Besides inappropriate health-related behaviours, the quality of one's social relationships, self-esteem, personality traits and stress sensitivity also have an influence on the mechanisms of risk factors and vulnerability. Sensitivity to stress is related to personality traits, genetics and biological and chemical functioning.

A study by cardiologists Friedman and Rosenman (1960, 1971, 1974), considered as a milestone in this research field, identified certain personality traits that increase the chances of a myocardial infarction and they created the notion of Overt Behavior Pattern A. It describes individuals exhibiting psychological constructs such as depression, anxiety, hostility and lack of social support. Several studies have already reinforced that these psychological factors play a significant role in the development of cardiovascular diseases and determine the severity of their outcome. However, these correlations should be treated with precaution and should be interpreted from different angles as understanding the underlying pathomechanisms is still an important goal of research today. Depression impairs the cardiovascular system through stress hormones. The level of depression correlates positively with the time elapsed between diagnosis and the cardiac event, and also with the number of acute myocardial infarction of fatal outcome (Ahern et al., 1990; Barefoot et al., 1996; Bush et al., 2001; Carney et al., 1988, 1995, 2003, 2005; Denollet et al., 1995; Frasure-Smith et al., 1995; Irvine et al., 1999; Kaufmann et al., 1999).

Psychologists working in cardiovascular care units have to deal with cardiovascular or circulatory diseases that may manifest in several different ways. A detailed description of these diseases is beyond the scope of this chapter. However, a basic understanding of the major diseases and medical practises is essential for health psychologists to be able to build rapport with their patients and understand their narratives; as having knowledge about the symptoms and the course of the disease provides the clues to predict a patient's expected psychological status and understand their reactions, experiences and emotions.

Disease	*Manifestation*	*Invasive Procedure*	*Psychological symptoms*	*Possible psychological intervention strategies*
heart valve disorder	stenosis or regurgitation	valve replacement	If congenital: anticipatory anxiety, grief and fear of relapse	Resource activation
arrhythmia	bradycardia (slow heartbeat), tachycardia (rapid heartbeat), atrial firillation	ablation, ICD or pacemaker implantation	symptoms similar to that of a panic attack; Fear of the possible next cardiac event might develop, which induces panic; Therefore patients might become confused because they do not know whether they have physical or mental problems	Reframing the dichotomous thinking concerning body and mind, Treatment of anxiety, In case of fear of an ICD shock: reduce shock anxiety, Thinking over life events, circumstance, schemas and scripts
myocardial infarction	one or more of the coronary arteries become blocked	angioplasty of stent implantation	trauma feelings of being puzzled: 'why and how could it happen?' 'But I ..'	Talking about the traumatic event, Embedding it in the patient's life course, Talking about its multifactorial etiology, Support patients' proper health behaviour development, Stress management
Ischemic heart disease	It develops slowly; Plaques build up in the coronary arteries thus decreasing blood flow to the heart, which subsequently weakens heart muscles and pump functioning – this eventually leads to acute infarction or chronic heart failure	Implantation of CRT or VAD	Heart failure involves severe physical complaints, diminished endurance and shortness of breath. These symptoms are frightening. Prolonged hospitalization resulting in regression, hospitalization syndrome, anger	preparation for surgery, postoperative ITON, positive affirmations, grieving the loss of previous established roles in life

Functional heart disease can result from impaired cardiac innervation, malfunctioning of the heart valves or poor blood circulation. The physical symptoms, length and mechanism of each of these diseases affect different mental functions, so we need to have different approaches and various methods and techniques to apply. In the summary table below we present the physical manifestations of the diseases, indicating the main psychological mechanisms and symptoms observed in our patients and the main areas that health psychologists should focus on. This summary cannot and does not aim to give a complete picture; rather, it serves only as a guideline for practitioners.

Heart failure – the long-term outcome of ischemic disease – is one of the greatest medical challenges of the 21st century. It affects a large number of people worldwide. It is a chronic, progressive disease with severe prognosis (Merkely & Becker, 2020), often requiring prolonged hospitalisations many times. Circulation support devices or heart transplant may be needed to improve long-term life prospects. The patients have to face their doubts and worries during their hospital stay, and may also be confronted with the possibility of becoming unable to manage self-care, which is highly frustrating. A prolonged hospitalisation might result in patients' cognitive decline, regression, and social withdrawal. Patients often display concentration difficulties, become impatient and negative with their relatives while they are feeling lonely. In such cases, it is advisable to focus their attention on preparing for surgery, attempt to activate their resources, validate and thus mitigate their anger and rejection. Building rapport before the surgery takes place is important as in the intensive care unit (ICU) the presence of a psychologist can give patients a sense of continuity and familiarity, especially in the first period. Keeping our scope and the boundaries of our professional competencies in mind, we can inform and educate our patients about how the time spent at ICU contributes to their recovery. Chronic diseases usually restructure patients' lives, alter their family and social relationship functioning and balance. Concerns about diminished or lost ability to work, the future, feelings of guilt or anxiety due to becoming a burden to family members and loss of physical activity are common. Each of these emotions influence the process of a patient's recovery.

2. CASE STUDIES

The following cases are mainly modelled on one particular patient's case, but to some extent we also have adapted parts of several of other patients' stories in order to provide as much insight as possible into the diversity of cardiopsychological care. These examples are supposed to enable us to present our experiences from a practical perspective.

2.1. ZOLTAN

Zoltan is a 50-year-old Hungarian man. Three months after having beeen placed on the heart transplant list, he was also placed on the emergency list (HU-highly urgent), and was not discharged until the donor heart arrived. The hospital care team asked us to provide psychological support for him.

Zoltan was diagnosed with hypertrophic cardiomyopathy at the age of 25. He received a prognosis of a four to five year survival. However, he did not notice any symptoms, was able to work, got married and had a child. He was offered a heart transplant, but he rejected it. As he did not develop symptoms, he thought his disease would not progress to the stage where such a serious intervention would become necessary. The fact that he survived the estimated period of 4–5 years also strengthened his conviction thereof. Zoltan managed to maintain his weight, avoided strenuous physical activity, quit drinking coffee and alcohol, which he used to consume occasionally when he was young. However, he began to experience gradually that his heart was 'messing up'. He attended check-ups, tests, followed all the medical instructions he was given, yet rejected transplant. Then, one day, while driving, he began to feel unwell, was short of breath, his heart rate increased excessively. The ambulance took him to hospital. Soon he got an ICD (implantable cardioverter-defibrillator) implanted. By that time, his physical endurance had seriously weakened. His fear of an ICD shock escalated as he was experiencing a shock with a conscious mind. He therefore re-considered his opinion on the heart transplant. Since his condition was deteriorating despite all the medication he was taking, he was referred to the Heart Transplant Committee.

During the first few sessions of counseling, Zoltan was talking in detail about his life story and his goals. His retrospective storytelling was a personal recollection of his past experiences through which he was able to recognize his resources, attained skills and knowledge. Using the mental technique of visualisation, he constructed and adjusted symbols to his resources so that he could utilise them whenever needed. During hospitalisation, he had difficulties getting used to being completely inactive. He spent time reading a lot about the surgery (gathering information). As for nonverbal techniques, drawing did not appeal to him, therefore we used mental imagery and positive affirmations. In order to avoid possibly emerging unpleasant thoughts related to breathing and heartbeat, we used muscle relaxation and visualisation for relaxation. We set up positive, peaceful images that he associated with positive, future-oriented visions that functioned as set future goals. He expressed how much he suffered from waiting and I reframed his emotions as valid, normal and healthy.

In the postoperative period, I spoke to Zoltan using our previously set positive images and affirmations until his mind became clear. I talked to him about where he was, how long he had been there and the actual date. I emphasised that he was safe and under our care. His heart worked well; however, his weaning off the ventilator was too slow. According to his physiotherapists, he was impatient with himself as although his condition began to improve, his ICU-stay became longer than he expected. During the postoperative period, he experienced some hallucinations as if they had been real, which also elevated his anxiety.

Day by day, Zoltan regained more and more control over his body; however, he began to worry about his mental condition. We offered him various tasks improving his skills in different domains, which eventually helped him regain his confidence about his cognitive abilities. Before he was discharged, we lined up the techniques he had developed and learnt, the difficulties he had overcome, thus reinforcing his belief in his inner strength.

Lessons learnt from this case

We often have got no clear idea what experiences patients go through during and after surgical anaesthesia. In the artificially modified state of consciousness, dreams and hallucinations become mixed with stimuli from the outside world and contents and emotions from the unconscious. Zoltan's case illustrates that – though not directly – it is worth uncovering these experiences. Patients might not come up with them on their own due to their bizarre and frightening nature nevertheless they suffer from their effects.

2.2. SARA

Sara is a 37-year-old female with a slim, athletic build, who raises her child alone. Her cardiologist recommended an outpatient appointment with me.

Sarah went to her GP 6 years ago due to sudden, rapid heartbeats who suspected her having mitral valve regurgitation (mitral prolapse). She had not experienced any health problems before, so she attributed her symptoms to her recent divorce and related stress. From then on, she went for regular check-ups. One day she suddenly felt excessively strong heartbeats, chest pain, dizziness and shortness of breath. The symptoms set in and passed so suddenly that she put them down to having panic attacks. When examinations detected no alterations in Sara's condition, she concluded that mental factors must have played a role in her malaise.

In the initial interview, Sara seemed optimistic, future-oriented, and objective with positive wording. Nevertheless, her body language and facial expressions conveyed anxiety. During our sessions, it became clear that Sara did a lot to maintain her health physically. She went for regular medical check-ups, exercised a lot, ate a healthy diet – she was really conscious in that respect. Her outward communication suggested that she accepted her disease, did her best to maintain her health and hoped for the best. However, the label of 'living with heart disease' triggered her fear of not being able to raise her child, as her heart could start pounding any time, which could be painful, uncontrollable, and she might even die of it suddenly. She felt despair and anxiety when these disturbing thoughts flooded her mind, especially when she was tired or had other problems that also induced anxiety. I advised her to use the VAKOG NLP technique to return to the present, do some physical exercise and take some deep breaths. Besides anxiety management techniques, we also aimed at normalising the extent of her worries and restoring her sense of control.

As her most powerful resources, she identified the time spent with her children and sports. As a result of my feedback to her on how strong she was to maintain her regular lifestyle despite experiencing such negative emotions, she realised that her steadiness and consistency also were a resource. She had not had a relationship since her divorce; she had withdrawn from dating as she felt nobody would accept her because of her illness. To balance out her negative experiences and fears, we focused on her being able to feel joy when men showed attraction towards her. It was also a great opportunity to turn her attention from her disease to normality. Regarding her friendships, she felt she did not have any close friends. I asked her about people who cared about her and with whom she could talk about her problems. She mentioned one of her colleagues with whom she had already shared her panic attack experiences and her sister who had offered to accompany her to hospital appointments and often asked how she felt. The strengthening of the personal support network around her added to her resources (Csabai, 2005). She started articulating her feelings more directly and talking overtly about her disease; this way, she could observe how others reacted, which changed her attitude as well. As a result, she started opening up about her negative emotions and could feel accepted despite expressing them, and she did not feel to be a burden.

In her last six years, Sara considered her family, job and health as the most important components of her life. She was successful in all these fields, yet she felt she lacked something. She said she did not notice that her fear of the disease set boundaries to her life. She perceived her illness as not being so severe, as her symptoms were rare and tolerable and she trusted her cardiologist and had a firm belief that her disease was treatable. Nevertheless, although good things were happening to her, she could not appreciate them. During a visualisation exercise, she envisioned her heart and interacted with it as a centre of emotions and joy. She tore down the mossy, thick, cold stonewall surrounding her heart and wrapped it around with a shiny, permeable protective layer that would allow experiencing beautiful, positive feelings and experiences.

In our further sessions, we proceeded to discuss her daily life events, experiences, and plans for the future. She experienced less and less worries and agony when she was talking about her worse days and managed to develop a mind-set that allowed her to accept happiness in her life.

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Part 5

FURTHER APPLICATIONS OF HEALTH PSYCHOLOGY

Leila Jagodics-Varga

CARING FOR THE CAREGIVERS.
PSYCHOLOGICAL SUPPORT FOR THE RELATIVES OF PATIENTS

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1. INTRODUCTION

If we hear about someone getting injured, diagnosed with a disease, or having an accident, we typically wish that nothing similar happens to us or our loved ones. However, when the reality of an accident or disease is up close and personal, what used to be so easily distanced from ourselves becomes undeniably real. We can feel in our gut and whole body that something is wrong. The feelings of confusion, despair, denial of reality, and hopefulness appear at the same time. Psychologists who work at a hospital meet people (not only patients but patients' relatives) with affective states similar to those described above, among others, during the treatment process after an injury. An illness or injury is always the illness of the relatives and immediate acquaintances of the affected as well (although not in a physical but in an emotional way), considering that the illness also appears in their life as a new phenomenon. It becomes a part of their life and may even override their normal routine and habits.

In the present chapter, I wish to introduce the clinical side of health psychology with an emphasis on some aspects of the psychological care of relatives and close acquaintances. Although the patient is in the focus of psychological care, the patients' relatives also play an important role in the prognosis of treatment and recovery.

The patients and the medical staff work in cooperation to manage the illness according to the modern approach (Pilling, 2008). Relatives can also be involved in this cooperation and may provide key information to the medical staff apart from visiting and being available for the patient. From the view of modern medicine, the presence of the relatives by the patients are now fundamental in medical practice: family-centric medical care has become the standard (Jolley & Shields, 2009).

Working as a health psychologist involves contacting the relatives of the patients. In the perinatal or neonatal intensive care units, relatives are the main target group of psychological interventions. Whichever the clinical ward, the presence or absence of relatives and their impact on the patient are to be considered during psychological care. This is because patients are part of a social network that is defined by the disease. Moreover, attitudes toward the disease may modulate the manner of social functioning within this network. Thus, patients should be examined as part of the social network that surrounds them. Knowledge of systemic theory and interventions serves as a fundamental background in the health psychological work with family members. By now, there is extensive literature on patient–relative relationship processes. For instance, it has been shown that the dysfunctional functioning of the family members contributes to developing and maintaining a disease, and the characteristics of relationship dynamics have previously been defined (Minuchin et al., 1975; Túry, 2000).

Family functioning and dynamics provoked by the new life situation vary from one family to another. The new functioning may not necessarily be a pathological one; however, changes in the previous equilibrium unavoidably leads to changes in the social network. Changes begin with the hospital treatment, but getting discharged poses another challenge to relatives and the entire family system. The presence of a disease affects the family members financially, physically, mentally, and psychologically. The loss of income, cost of treatments, and taking physical care of the diseased person place another burden on family members, who often are already under a considerable weight (Goldberg & Salloway Rickler, 2011). Family members' anxiety about their role, changes in social life, negative changes in emotional state, previous losses, and fear of unpredictable future losses also contribute significantly to their physical and mental deterioration (Askari et al., 2013; Carlozzi et al., 2015).

The main principle in health psychological work is to steer the above-mentioned psychological processes in a direction that supports well-being the most. The flow of psychological support is determined by the individual and the actual situation. Thus, the work with a client is always unique and personalized. A client can be anyone who attends psychological counseling: either a person undergoing hospital treatment/healthcare service or their relatives.

Psychological care in a hospital setting has the characteristic feature of not always being initiated voluntarily, driven by internal motivation. Furthermore, the traditional therapeutic frames regarding dual relationships cannot be maintained in all situations. Diversions from these therapeutic frames involve the location (e.g., counseling by the bedside), circumstances (e.g., patients in severe pain), undisturbed process (e.g., the presence of others in the room), as well as the time and time frame of the counseling (e.g., the duration of counseling cannot be precisely predicted). Additionally, secret-keeping cannot be secured in all circumstances. Working with the patients' relatives shares the same uncertainties; although, it is easier to establish therapeutic frames with them.

Providing support to relatives may occur on several levels in a clinical setting. The determination of family involvement is based on the model of Doherty (Doherty, 1995 in Hawley & Dahl, 2000), which I adapted to clinical work.

Minimal connection is when the relatives know about the psychologist, but there is no direct contact between them. Regardless, the attitude towards one another (e.g., expectations, presuppositions, and fantasies) still influences the psychological process through the patient. The next level of connection is when there is an introduction or even a few sentences exchanged. This act is able to modify the preexisting fantasies and generates new ones at the same time.

On the next level, the client already shares some personal content and connects to the psychologist who has started an intervention. A common situation that also poses a professional dilemma is when the relatives react to the presence of the psychologist by sharing their personal struggles, while the psychologist is committed to a therapeutic process with the patient in that situation.

The level of involvement is the same as in the previous example when the relatives approach the psychologist aiming to gain information regarding the current state of the patient or to understand the psychological effects and treatment opportunities. This primarily requires psychoeducation which is usually terminated after a few sessions.

The closest connection is established with those relatives who ask for help in a voluntary and motivated manner in solving their problems and alleviating their difficulties. In this case, therapeutic goals other than psychoeducation may be set, and more of the psychologist's methods may be utilized. Securing the therapeutic frames is the most feasible on this level since the sessions are easier to schedule.

Supportive connections that are the amalgam of the latter two levels may also be realized in a hospital setting. This connection generally occurs with patients with a critical or severe condition or who are bedridden. In these cases, the connection between the psychologist and relatives develops spontaneously rather than planned, often by the bedside or during visitation, and is most commonly initiated by the psychologist. The encounters may include one or a few more sessions; however, these are usually connected to an emotionally loaded situation (e.g., a change in condition of the patient). Deeper psychological content generally appears spontaneously as a result of the situation.

The psychological work in these cases primarily has a supportive nature or involves crisis intervention. If the patient's condition worsens, the talk with the relatives has focus on the change-related emotions, whereas we conduct crisis intervention if the relatives just received the news of an accident or death. Nearing the patient's death or when saying goodbye to a passed relative, the aim is to support saying goodbye and improve the psychological and physical state associated with the experience of loss. Additionally, supporting the maintenance of a fundamental physical condition, such as bringing the relative a glass of water or encouraging them to eat or go outside for fresh air, may also be the task of the professional.

It is clear that health psychologists have a wide variety of clients with a great variety of problems and can encounter truly special and unique circumstances. From this wide range, I wish to elaborate more on the psychological work with grieving relatives in this chapter since grief processing forms an integral part of the counseling process in the case I will present.

2. BRIEF INTRODUCTION OF THE GRIEF RECOVERY METHOD

As shown in the above-presented examples, caring for people who have experienced or are experiencing a loss is an inevitable part of the helping profession. Thus, it is of importance for professionals to have sufficient knowledge of grief. The Grief Recovery Method (Friedman & James, 2011) offers valuable knowledge. It covers how to guide attitudes towards grief and what factors to consider during counseling apart from gaining personal experience. The basis of this technique is an action program for moving beyond any kind of loss. Once mastered, this method can aid the processing of loss for a lifetime. The method was developed in the United States by John W. James and Russell Friedman, who were motivated by their own grief to create an effective tool for themselves. They later used the method to also help others. The approach has been organized into a transcontinental network, bringing the opportunity of help to millions of people in many countries. Specialists trained in Grief Recovery Method are those who attend people during the processing of grief and teach them the steps of the action program using the Grief Recovery Handbook. An important aspect of working together involves the establishment of connectivity, reciprocity and a safe holding environment (Friedman & James, 2011)

3. CASE REPORT INVOLVING THE GRIEF RECOVERY METHOD

The case presented below is of a client who approached me as a relative searching for help to process grief after a sudden loss. Interestingly, I had not met the client herself before, while the patient was at the intensive care unit, even though I met some of the relatives. A psychologist colleague referred the lady to me. I will name her Dalma in the case report. When she contacted me on the phone, Dalma mentioned that she had developed panic attack-like symptoms since the death of a relative.

During the first in-person encounter, I met a young lady in her twenties who wore dark but not entirely black clothes. She appeared neat and well-groomed. Her short and trendy hairstyle, and her accessories were indicative of a youthful, lively, and colorful personality. Her determined upright posture and searching gaze suggested that although she was anxious, she tried to overcome her anxiety and to show strength and firmness to the outside world. During the phone call, I pointed out to Dalma that the counseling is held within the intensive care unit. I always shared this information with the relatives who came for counseling, because the two consultation rooms I used as a psychologist to receive my clients were the same rooms in which doctors informed the relatives (and in which the relatives usually received the bad news). Therefore, I took into account the fact that the location where the relatives receive the bad news has a special meaning and is often loaded with anxiety and painful memories for the grieving person.

We walked to the consultation room together with Dalma after introducing ourselves. She followed me after a big sigh, gathering the strength to enter the room. I offered her a seat at the beginning of the conversation. She looked around in the small room and decided to sit on a different place from where she had been sitting when the doctor had informed her. Right at the start of the consultation, I asked her how it felt to be sitting in that room. In response, she recalled the occasion when she was there listening to the doctor, at first hopeful and then devastated by the bad news. Dalma reported that it is not in the intensive care unit but the room of the deceased relative where her anxiety is the worse. She then shared with me the details of the event which I only read in the medical history.

Dalma was the future daughter-in-law of a patient, called Krisztina, treated in the intensive care unit. Krisztina lived in a family house with her older son and his partner (i.e., Dalma) along with her other son of grade school age from her second marriage. They also had two dogs. Krisztina and her smaller son slept in one room, while Dalma and her partner slept in the other. However, they mainly used the common spaces in their daily lives, so they met and talked regularly. Dalma described her relationship with her future mother-in-law as strong and trusting: *"she was like a friend and sometimes more like a mother to me."*

Dalma could not recall any occasion when Krisztina complained of any physical symptom before the night she got sick. On the contrary, she looked excited because of an upcoming joyous event. During the night, the little boy noticed that her mother who was asleep on the other bed *"was breathing strangely"* and when he could not wake her, he alerted his brother and Dalma. They called an ambulance after another unsuccessful attempt to wake Krisztina up. While the older brother was checking the state of Krisztina with the help of the dispatcher until the ambulance arrived, Dalma calmed the younger brother down. The ambulance arrived fast and began the resuscitation. Dalma was simultaneously focusing on the state of the little boy, the restless dogs, and the events surrounding Krisztina. The memories of the resuscitation attempts, the instructions, and the insertion of the breathing tube burned into Dalma's memory. *"If I close my eyes, I see the whole scene in front of me. If I go into that room, I have flashbacks of the events. So I don't go into that room unless it's necessary."*

Krisztina was resuscitated and then brought to the hospital. Medical examinations revealed that she had suffered a heart attack in her sleep and that the oxygen deprivation caused significant brain damage. She was admitted to the intensive care unit in an unconscious state and received mechanical ventilation, as well as considerable pharmacological treatment. Although she was brought to the hospital due to a heart attack, her heart recovered as a result of the treatment. The brain damage due to the heart attack was so severe that it could not be resolved despite all medical efforts. The patient eventually got to a near-brain-death state. This was followed by the diagnosis of *"brain damage incompatible with life"* a few days later.

Family members and close friends were visiting Krisztina constantly throughout that time. The recovery of her heart gave some hope to the relatives. They were talking optimistically to the unconscious Krisztina, whom they described as a *"real fighter."* One of the relatives commented on her initially: *"If someone can recover from such a condition, it will be her."* However, it soon became clear that the brain damage was irreversible, and being hopeful turned into anticipatory grief displaying all characteristics according to the book. Some family members began accepting the probability of Krisztina's death, while others expressed their pain over the loss in the form of anger. They were looking for causes and someone to blame. They turned their anger against the medical staff. Some relatives started searching for alternative treatment options despite what the doctors said. I made direct contact with Krisztina's sibling, older son, and two close friends; however, I did not meet Dalma at the time. The acceptance of Krisztina's nearing death was aided by the spiritual belief and supportive attitude of the family.

From Dalma's story, I learned that another loss was associated with Krisztina's death. The younger child moved to live with his father and his father's new family. It was initially a temporary solution; however, with Krisztina's death, it became permanent. Dalma contacted me a few weeks later but prior to the memorial service.

She reported intense anxiety and panic attack-like symptoms since the night of Krisztina's heart attack. These symptoms appeared any time during the day but mainly occurred in the evening. Being alone made her feel anxious. Whenever she could, she sought company, either in person or by phone. She admitted that there had hardly been a day when she had spent even an hour alone. During the days when she was at work, she was more easily distracted (she worked in retail). Her partner worked in changing shifts, so he sometimes returned home in the late hours of the evening. On these days, someone stayed home with Dalma or his partner requested changes in his shifts so he could come home earlier. In her anxious state, Dalma experienced compulsive thoughts: *"Something's going to happen to me too," "What if I have an attack as well?"* Her partner was a comfort for her, but she still could not sleep at night for more than a few hours due to her anxious thoughts. It must be mentioned with respect to the medical history of Dalma that she underwent heart surgery as an adolescent. Due to the procedure, she regularly took medication which maintained her heart in good condition. Nevertheless, the death of Krisztina accelerated her anxiousness about her own health status. This resulted in a more severe panic attack, after which she visited the medical on-call service, and later she made an appointment with her family doctor to consult on her current medication status. On the other hand, Dalma emphasized that she did not want to take as much medication as she had after the surgery. She considered it a success that (even though she had had a major surgery) her condition rapidly improved with the adequate medication and her responsible attitude. Her experience was that the surgery did not hinder her almost at all in her everyday life.

She also felt anxious about what would happen on the memorial service in her heightened emotional state: *"How can I get through it?"*

Dalma also shared with me during the first session that she had lost her father a few years earlier. Although she had not maintained regular contact with her father after her parents' divorce, she reestablished a stronger bond with him when she was a young adult. Dalma was devastated by the death of her father, but in her opinion, his prolonged illness had prepared her to say goodbye. The suddenness of Krisztina's death, on the contrary, was *"a bolt from the blue or even worse."*

Dalma contacted me, determined to understand what had happened to her and overcome her anxiety. *"I want to get my old self back." "I have to face my fears."* This set a base for our work together.

3.1. PSYCHOLOGICAL CONSIDERATIONS

Initially, the two of us were sitting in that small consultation room with the shared knowledge of what happened at the intensive care unit, which developed a kind of connection between us. Then, as Dalma gradually allowed her personal experiences of the events to surface, her personal losses revealed themselves more and more to me as well. It involved the tragedy of suddenly losing what had been stable relationships, as well as the deep and trusting bond with her future mother-in-law, who gave her emotional support at the same time.

I find it important to always highlight for the relatives that they should only share with me as much as they are comfortable with at the moment. It is important to avoid the clients feeling compelled, tasked, or required to share the events when they are healing from grief and trauma. Of course, from a psychological counseling perspective, asking questions that go deeper is inevitable. Still, I consider it important to give the clients space to decide how much they wish to share from their traumatic events. After all, clients know the best what they can handle at the given moment. My responsibility as a professional is to create an environment in which the clients feel safe to open up and believe that I can hold the painful burdens they sometimes struggle to shoulder. Trust is not complete by the first encounter; it develops as a result of the professionals' empathetic feedback and resonance with the emotional state and story of the client throughout our work together. Therefore, we need to take into account that clients might knowingly omit some details or do not let the session go below a certain depth. This decision must be respected even if it somewhat hinders the understanding for us.

It became evident that the determined and somewhat impatient behavior of Dalma stemmed from how much she suffered from her condition. She wanted her pain to be mitigated as soon as possible. I had to psychoeducate her on grief along with the disadvantages of the rapid management of grief reaction and pain without invalidating her suffering and her wish to manage her situation somehow. Educating Dalma on emotions and grief reactions could normalize her intense reactions on the one hand. On the other hand, by learning that grief can include a range of extreme reactions, she was able to put her own condition into a new, less catastrophizing perspective.

Apart from grief, in the case of Dalma we had to focus on her health anxiety associated with her heart condition. As a professional, I had to consider Dalma's condition as an actual risk factor. To this end, medical examination was essential. If Dalma had not initiated a medical examination, the motivational interview would have also been part of the first session as a health psychological intervention. Given that Dalma had done steps to get examined, the main lead of our work was to normalize her physical state by managing her mental state.

Similarly to psychoeducation about grieving, education on the symptoms associated with panic attacks is also important to patients experiencing panic attack-like symptoms. Dalma feared that the panic attacks she experienced would lead to the development of another disease. As Dalma described, the events she experienced triggered panic attacks; however, her anxiety was clearly linked to the recent death and the events associated with it. Thus, I classified what she experienced as an acute stress reaction. With psychoeducation, we corrected her sense of being labeled as a person with a mental disorder (i.e., panic disorder), which helped Dalma perceive her situation as more manageable. At the same time, it also prevented her fear of developing another disease.

Naturally, we cannot expect the cessation of the symptoms from this intervention only; therefore, psychoeducation must be complemented by other therapeutic elements that offer measures to manage the situation. In these cases, relaxation techniques may be considered. In the first session, as a psychologist, I always base relaxation intervention on the existing techniques of the client. The same applied to the case of Dalma on our first session. Everybody has certain stress-relieving rituals and behaviors, as well as situations that have a calming effect on them. A brief exploration of these factors can help in choosing what technique to recommend. In most cases, I teach some of the basic moves of progressive muscle relaxation (Jacobson, 1938) to clients suffering from anxiety, as it is easy to acquire. The advantages of this technique include that it can simply be linked to previous experiences, and it does not require any equipment, only the muscles and attentional focus of the clients. In an emotionally loaded situation, difficulty concentrating is commonly experienced. Thus, it is of great importance to secure an appropriate environment for teaching these techniques to the clients as this environment will be associated with a sense of peace. Nonetheless, practicing away from a somewhat safe environment is also crucial in acquiring such a technique. Accordingly, we discuss the situations with the clients in which they believe they can practice the movements of the relaxation. In the first session, I advise against immediately testing relaxation in the situation associated with the most anxiety. This is because a technique that is not wholly acquired is less likely to override the overbearing anxiety they experience. I also advised Dalma to practice muscle relaxation in situations that (according to her) induced mild levels of anxiety. She was encouraged to observe the effects of the technique.

When Dalma recounted the events of the night of Krisztina's incident, she strikingly avoided being specific while describing the events. Instead of being concrete, her expressions were vague and obscure. This phenomenon is the equivalent of a reaction to distancing and avoidance in grief. It may help in certain cases to prevent the psyche from getting overwhelmed by the problem. This coping mechanism may temporarily help the client and may be needed in some life situations. However, psychological work should aim to reduce the use of such coping strategies. In the case of Dalma, I gave moderate, but firm feedback; it also started a discussion about distancing. Apart from encouraging her to accept the grief reaction as normal, I also tried to make her recognize that the grief process is hindered by her avoidance of telling things like they are. *"We are here together with the intention to face your fears, but it will not be easy if you cannot even name them."* A well-chosen metaphor might be of great help to start reframing in similar cases: *"I have a feeling that we are talking about this like the characters in Harry Potter talk about Voldemort whose name they dare not utter. This is actually what makes Voldemort terrifying. Harry utters his name from the beginning and is also able to face him later."* The shared knowledge needed to understand the metaphor forms a bridge between helper and client and also between the problem and the person burdened with the problem. At the same time, it must be pointed out that a metaphor that is too complex or requires too much explanation may hinder the connection and understanding. This is especially relevant if the client is in an altered state of consciousness due to grief, anxiety, or trauma or if the client's current mental state (e.g., difficulty concentrating, information processing difficulty) makes it difficult to comprehend abstract non-tangible notions.

In the first session, my therapeutic work was centered around my holding function (i.e., to hold the patient). Furthermore, I tried to normalize her experiences, support the reframing of her experiences with psychoeducation, and delineate the goals of our work. The grieving young woman's anxiety posed a professional challenge to me. I had to take multiple factors into account in this situation. On the one hand, I felt the need to support the client with some kind of intervention that improves her coping. On the other hand, I was aware that one session would not be enough to achieve remarkable reduction of the burdening symptoms. I was a bit afraid that the symptoms would intensify with the nearing of the memorial service or due to other triggers, while the existing coping would not be sufficient to manage the situation. However, I also trusted that Dalma would be able to ask for help if needed. Nevertheless, I had to take into account that her previous heart surgery was associated with some risk (the level of which was unknown for me at the time). Therefore, I could not have been sure that I had found the appropriate balance in supporting her in developing a realistic attitude towards her symptoms. By this, I mean that first, risk factors have to be considered. Second, clients should be encouraged to avoid attributing too much importance to one symptom or another. Third, I had to think from a professional point of view about in what order to work with the problems the client had brought to me. Among panic attacks, grief work, and health anxiety, which was associated with the highest risk?

3.2. DESCRIPTION OF THE THERAPEUTIC PROCESS

During the second session, we decided to dedicate the next few sessions to the management of situations that trigger anxiety. We agreed to start learning the Grief Recovery Method following that. The focus of the conversation was Krisztina's memorial service. Dalma recalled painful but relieving memories regarding the event. She gained a positive experience about herself: she expected herself *"to have a breakdown";* however, it did not happen. She proudly told me about having some nights when she had been able to sleep more peacefully after calming herself down.

In the second session, Dalma introduced another topic that significantly affected her life. She talked about how her view of herself had changed. As it turned out, one of the most unexpected experiences of the grief process for her was that she felt as if the way she had described and known herself before had become distorted. She described herself as having a cheerful personality, a positive attitude, and a focus on finding solutions. Her currently anxious, highly sensitive, and almost helpless behavior was in contrast to that picture of herself. She had a recurring thought describing her experience: *"This is not me! Am I going to stay like this?"* Regarding this thought, we talked about how any loss could create a situation where things that were previously believed to be solid points become uncertain. The previously known routine could fall apart, and temporarily, no new routine would develop. A new routine would only appear as a result of successful coping with the new situations. It was clear that Dalma was experiencing an accidental crisis, so psychoeducation was conducted accordingly.

The following quote of Dalma made me realize how deep a change she experienced: *"Will I ever be able to smile truly and honestly?"* This sentence echoed between us as if even the possibility had become uncertain that this condition (which currently immobilized and kept her down) could change. This sentence and all the feelings behind it had a deeper meaning that went further than the simple questioning of capacity for joy. Although this was not the focus of our work together, it was a recurring topic from time to time that we covered.

Dalma was unsure how she would function in a group of friends and how her debilitating anxiety would impact her relationship with others, especially her partner. Dalma was afraid that she would overwhelm her partner, who was also struggling with the pain over the loss of his mother. Dalma's partner had a key role in managing Dalma's anxiety on top of all the other things. He was the one to take Dalma to the on-call family doctor; thus, he was on constant alert. Dalma believed that her anxiety did not allow her partner to relax (e.g., at a social gathering), because he was the one she could turn to with her problems. Moreover, in some cases she felt anger if her partner did not care about the risks or thought Dalma's reaction was overexaggerated. These feelings accelerated the tension between the two. They were having arguments several times. This change made Dalma more uncertain and raised concerns in her about their relationship.

Dalma's beliefs behind her fears gradually revealed themselves during our talks. A cognitive approach to anxiety appeared to be the right method to manage the distressing thoughts that emerged from the exploration of her beliefs. Therefore, I used this approach to help her coping. During our work together, I first introduced Dalma to the cognitive approach of anxiety. During psychoeducation, I also detailed the characteristics of beliefs, negative automatic thoughts, and cognitive distortions. We identified the negative automatic thoughts and the emotional, behavioral, and physical factors associated with them during our sessions. Furthermore, I introduced her to the method of reality checking. Dalma was really open to the idea. She identified feeling tightness in the chest as the most prominent symptom of her anxiety. This bodily sensation was accompanied by thoughts that there was something wrong with her heart again or that she might have a heart attack like Krisztina. On an emotional level, she reported an increase in anxiety and insecurity, and a reduction in feeling safe. As her anxiety increased, so did her physical reactions, prompting Dalma to seek company, not be left alone without help, and take her heart medications and sedative pharmaceutical products. The avoidance behavior she developed to manage her anxiety included not going to places like closed corridors and the back staircase, where her sense of loneliness increased. To the avoidance behaviors, a belief was coupled that if she had an attack, she would not be discovered in close spaces; hence, she would not be able to receive help or ask for it. Our discussion about the possible reasons behind her bodily feelings and reactions to stress, as well as exploring the negative thought spiral helped me understand how her anxiety could escalate. This knowledge gave her another interpretation framework for understanding her own behavior, which helped her developing a more realistic image of herself and considering herself capable of dealing with the distressing situation. I also introduced her to relaxation techniques as an additional line of intervention. We practiced mindfulness relaxation with the help of a smartphone application, which became part of her life because of its easy accessibility and usability.

In addition to the management of her anxiety, we also talked about her experiences regarding grief, comprehending that the trigger was a case of death. During our work together, Dalma had to face other loss experiences (both related to relationship, family, and work) on which we focused our attention during one session. The cumulative grief events brought a transitory deterioration in Dalma's anxiety management, but as we progressed with the counseling, these relapses became shorter and shorter.

We only started to involve the Grief Recovery Method when her intense bodily symptoms reduced, and her sense of control strengthened. At that point, I also encountered a professional dilemma given that starting the grief process might significantly set back the progress made so far. Until the client's condition is not sufficiently stabilized and the new skills are not firmly established, professionals should take this risk into consideration. At the same time, based on Dalma's description of the grief events, I had a feeling that it would be unfavorable to neglect the deeper processing of grief for a longer time. The recall of loss is typically a disturbing experience, both at the beginning and later stages of the grief process. I informed Dalma about the possible relapses and the state we commonly refer to as an emotional rollercoaster in everyday life.

Since Dalma was motivated, open, and determined, we eventually began the grief processing according to the schedule of the Grief Recovery Method. The initial phase of our work together allowed us to discuss the expectations from her environment towards her regarding how to manage her grief. We also discussed the beliefs that were associated with these expectations, and we could evaluate together how much these factors limit or support her in experiencing and expressing her grief.

As we advanced with the grief processing, social events had started to reappear in Dalma's life. However, due to her emotional state, she felt like she was unable to lightheartedly attend these events, she was rather tense and stiff. Her desire to experience her presence in social gatherings as she did previously made her impatient: *"I would like to get over this all and feel well again. How long will it be this way?"* It seemed like the improvement she experienced made Dalma believe that what she had achieved would help her leave the pain behind soon, including the unusual experiences of herself and the sleepless nights caused by her anxiety. Dalma arrived at the next session with a new hairstyle and hair color, wearing colorful summer accessories. Commenting on her new look, she said: *"We cannot get stuck."* This expression seemed to serve as a motivational quote for her. It triggered her to make visible changes in her life. I have encountered similar events a few more times during our session. This told me that Dalma was starting to regain control over her life and that she now felt able to allow other kinds of experiences close to herself.

One of the deepest processing experiences during grief processing is usually the overview of the loss experiences and their placement on a timeline. I detected a significant setback in her condition after we reviewed her losses. Although having relapses is an integral part of the process, two major losses concerning her close friends contributed currently to the worsening state of Dalma. We began to process her relationship with her mother-in-law in this time period. Although the current losses deeply impacted Dalma, she was able to dedicate herself to the processing of this relationship with undivided attention. They got along well since they first met, but moving in together is what made their relationship became truly intimate. Dalma considered Krisztina a good friend, sometimes a mother, to whom she could often turn for advice and emotional support in sad and uncertain situations or when facing a dilemma. Often, Krisztina was the one to help Dalma escape from her ruminative state and facilitate her to decide or take action without deciding instead of her. As a result of Krisztina's support and encouragement, Dalma continued her studies and opted for different courses. As she talked about their relationship, it felt like with Krisztina's death Dalma had lost a person who had been a pillar of her strength. Similar to most people who grieve the loss of a special relationship, Dalma's relationship with the deceased could be described as a feeling *"like losing a part of myself"*. Although the psychological interpretation of this sentence may be indicative of dependency, it is not necessarily the case. Naturally, dependency might need to be considered in some cases. However, the Grief Recovery Method, being a self-help method, does not include the processing of pathological grief processes.

In parallel with the grief processing, Dalma further improved with her anxiety management. She independently set herself new challenges to herself confronting herself with situations that had previously anxiety inducing. One example of such a situation is when she stayed at home alone for a more extended period of time. During this time, she consciously focused on not looking for a social distraction (e.g., talking on the phone) as she used to do. She reported as a success that she took time to review her negative automatic thoughts and do a reality check at the beginning, which reassured her.

After finishing the Grief Recovery Method, we met a few more times. These sessions focused on a journey and Dalma's fears with respect to the trip. Travelling abroad aggravated her fear of a sudden illness and the negative automatic thoughts she previously had. Therefore, we once again focused on practicing coping strategies and management options for a few sessions before the journey. Although being away from home and the seemingly risky situation of travelling by plane posed a challenge to Dalma, she did not experience panic reactions. She was also able to rapidly overcome her anxiety during the flight. The experiences she gained reinforced her self-image and made her more self-confident.

Another event to be highlighted was that Dalma finished a course she started before and she begun to work in the field. Her choice of profession of doing therapeutic work with dogs stemmed from her love of these animals. Initially, while grieving, she was hesitant to engage in this profession more seriously due to her timidity and feeling of being inexperienced. During our talks, she often listed counterarguments and excuses of why that was not the time to embark on this interest. What gave her a little push was a special offer. She started to work with a dog that needed to be handled especially carefully. Despite the challenging task, Dalma felt that she was able to help. Although her insecurities had not ceased, considering the effectiveness of the therapy, she was becoming more confident in her work. Because of this course, Dalma could immerse herself in an activity that she did out of intrinsic motivation.

Nearing the termination of the counseling, Dalma seemed to have returned to her old *"colors"* both according to her opinion and appearance. At the same time, she could also integrate her feelings of grief. Her experience that she was able to rise from such depths she felt stuck in increased her self-confidence and helped her acquire new skills. From the feelings of confusion, impatience, and helplessness shown during our first session, Dalma moved on to a state that she can manage and is more harmonious with her inner emotional states, characterized by more focus, patience, and control over her life. Her working as a dog therapist is an example of posttraumatic growth in grief.

Our follow-up appointment happened three months after the termination of the counseling. Dalma's work life changed for the better as she got promoted. This was associated with increased responsibility, but at the same time, it was also proof of her competence. As part of planning their future and saying goodbye to the memory of Krisztina, she and her partner packed up Krisztina's former room. Furthermore, they started to remake the room and the common rooms to better meet their needs. Dalma commented on this as follows: *"we have only started to actually become a couple."* With that, she emphasized that they could not experience how they were as a couple (e.g., in what environment they felt comfortable living in, how they liked to organize their daily life) while living with Krisztina and her younger son. They were able to take their relationship to a new level following the unexpected loss, and experiencing these changes further strengthened their relationship. Their future plans included starting a family. We had talked about them having children before, but it seemed to me that Dalma placed it into the distant future. In the follow-up session, it appeared that Dalma and her partner were preparing themselves for this commitment. The notion now seemed to be placed in the near instead of the distant future.

4. DISCUSSION

Dalma's case illustrates the emotional changes of the relatives following an unexpected injury, illness, or loss, as discussed in the introduction section well. Experiencing bodily changes that were also limiting her daily life and an inability to cope with them prompted the young woman to seek professional help. The focus of psychological work involved interventions to manage the bodily changes and grief processing. Dalma was able to effectively employ interventions that improved coping. As a result of her motivation, ambitious and problem-centered attitude, and consciousness, she rapidly overcame anxiety-inducing situations. This case, in many ways, is an example of successful coping and effective use of resources.

Following Dalma's case, readers might easily have the impression that psychological counseling, therapy, and grief processing involving relatives is usually a smooth and successful process. In reality, however, it is more likely for the psychologists to face several relapses, stagnation, reduction in motivation, psychological and mental issues, and social difficulties that might go beyond their competency. In these cases, the involvement of other professionals (psychiatrists, social workers) might be necessary.

The case presented here draws attention to the importance of professional self-knowledge and personal involvement. The considerable anxiety and suffering caused by grief-induced pain that can be observed in the first appointment affects the clients on a visceral level and makes them strive to get rid of these feelings as soon as possible. The psychological pressure of suffering that motivated the client to contact me was detectable in the therapeutic space. In the form of transference, I also experienced the feeling of being urged during my talk with Dalma. This automatically brought me a thought that was undoubtedly stemming from the client: *"Let's quickly do something, anything really, just to get over with it!"* I also found myself starting to think about what rapid solution I could offer her. In this context, it was important to consider what options are available for intervention and how applicable these are in the given situation without misleading the client by suggesting that her problem can be easily and rapidly solved. During the evaluation, I also had to bear in mind that along with immediate help, I had to consider professional points of view that supported the necessity of a slower and long-term process and more careful application. Offering a simple and fast solution to a problem might create false illusions and convey a message that the current situation can be effectively managed easily by investing low energy. However, this illusion falls apart fast in practice due to the nature of the problem. This might undermine the therapeutic relationship and the clients' trust in herself and the psychological work. In order to avoid this, it is of great importance to provide adequate information and check if the clients have understood the possible effects and the conditions of an effective intervention.

Psychologists should approach their job with appropriate flexibility, particularly when working with relatives at the bedside. The limited predictability and uncertainty impose a burden on psychologists as well. Thus, finding adaptive coping methods is essential to work effectively and prevent burnout.

Lessons learnt from this case

The visceral response to loss can make a person with previously effective and adaptive coping strategies helpless and insecure in their identity and daily activities with significant intensity and pace. Seeing the suffering caused by grief, panic attacks, and anxiety urges the professionals to provide effective help as soon as possible. However, the positive experience of accompanying the clients through the healing process despite the overwhelming urge for immediate help and the way we offer a range of interventions as professionals to guide the clients through the difficulties that inevitably arise during the procedure is an important lesson to learn.

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SELF-HELP GROUPS FOR PATIENT SUPPORT

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1. INTRODUCTION

The roots of self-help can be tracked back to ancient times. Even according to biblical doctrines, it was a moral duty to help oneself and others in need (Kéri, 2011). Self-help patient groups were created on the basis of the needs of those with the same pathology or problem; for example, mutually helping each other by sharing their experiences. Among its members there were stigmatized or deviant people, or followers of alternative lifestyles, as well as voluntary associations of people with chronic diseases (Csepeli, 2001; Jacobs & Goodman, 1989; Katz, 1993; Katz & Bender, 1976). The ways these groups are operating are very similar, they are organized along particular diseases and their aim is usually to promote healing; using group-cohesion, strengthening the sense of belonging, sharing personal and other experiences (Katz, 1993; Katz & Bender 1976). Several studies describe that participation in patient groups relieves anxiety caused by diagnosis, by examinations or by therapies, and can improve adaptation to diseases (Campbell et al., 2004; Meyer & Mark, 1999; Newell et al., 2002; Poole et al., 2001).

Patient groups are characterized by advocating the rights of patients, and/or educating patients. Education facilitates the knowledge of the disease and the patient's path, can improve communication skills, develop appropriate coping mechanisms and promote desirable psychological well-being, all of which can significantly increase persistence and adherence (Cain et al., 1986; Docherty, 2004).

Meetings of patient self-help groups may be based on different approaches, and the gatherings may differ both in nature and in dynamics. The meeting can take place in person or online, can be open or private, ad hoc or regular, and can be organized thematically, led by experts. The main goals are emotional support, sharing similar experiences of fears and experiences, increasing the individual resources of each patient, reducing anxiety, expanding coping strategies, helping rehabilitation, and enhancing social support. It is typical in the open-attending group that the members are not permanently present, the meetings are incidental. The permanent membership of the private group increases the experience of belonging.

The largest number of patient support groups were organized for cancer patients with significant distress in order to strengthen the patient's sense of control, the patient's belief in his or her autonomy and to help them make decisions by having better access to information (Anderson & Funnell, 2005; Hibbard et al., 2004; Newell et al., 2002).

Self-help group meetings are characterized by thematic regular meetings, exchange of experiences, psychosocial support, organized and led by experts (such as health psychologists) (Gutgsell et al., 2013; Teo et al., 2019).

2. SELF-HELP PATIENT GROUPS OPERATING IN HUNGARY

In Hungary, the roots of self-help activities go back to the period before the Second World War, as some self-help groups were formed at that time, but they were quickly disbanded due to the political and social situation at the time. In postwar times, the first self-help group organized by alcoholics began to operate in 1955 with the aim of strengthening members and overcoming harmful dependence or counter social exclusion. This self-help group became the early predecessor of today's organizations of alcoholics (Gerevich, 1983). The real change was brought about by the previously mentioned Health Preservation Program, which was drawn up in 1987, and then the Law on the Right of Association, which came into force in 1989, made it possible to organize self-help groups ("Egyesülési jogról szóló törvény"; Kéri, 2011).

The Hungarian Anti-Cancer League was founded in 1990 to help cancer patients. It has considered health promotion as its main task and has drawn attention to the importance of early detection of the disease, participation in screening tests and self-examinations. They regularly provide rehabilitation-club meetings to people with the disease, and they also provide legal and psychological support to both patients and relatives. Over the years, more and more self-help groups have been formed along the lines of various diseases or disabilities, and they have been working successfully ever since. Examples include "By Heart" National Patient Association („SZÍV SN Országos Betegegyesület"), the Stroke Info Foundation („Strokeinfó Alapítvány"), the National Association of People with Rare and Congenital Disorders („RIROSZ – a Ritka és Veleszületett Rendellenességgel élők Országos Szövetsége"), or the "Mauve Flower Association" „Mályvavirág Egyesület", which helps women with cervical and ovarian cancers.

Self-help groups and organizations have been formed in Hungary to help women with breast cancer, similarly to many countries around the world (for example in the USA, Netherlands, Germany and Poland). The "Bridge of Health Association against Breast Cancer" („Egészség Hídja Összefogás a Mellrák Ellen") is about 17 years old; the "Pink Bolero Self-Help Association against Breast Cancer" („Pink Bolero Önsegítő Egyesület a Mellrák Ellen") was founded 10 years ago; and the "My Tomorrow Association – Together against Cancer" („Holnapom Egyesület – együtt a rák ellen") was organized in the city of Debrecen. There are several groups active on online platforms, such as the "Breast Cancer Information Association" founded about six years ago

(„Mellrákinfó Egyesület”), the “Do It for Yourself” („Tegyél Magadért”) or the “Breast-Protect” („Mell-Véd”) self-help groups. These patient helper groups usually form closed meetings, making them suitable for truly confidential conversations.

Self-help patient groups play an important role in the lives of diagnosed patients and their relatives in Hungary, as well as in other countries of the world. These regular appointments and programs help to adapt to the disease, relieve anxiety and fears, while increasing the experience of belonging. Asymptomatic patients often take on a voluntary helper role, so the experiences they share with their newly diagnosed peers are truly credible.

3. PINK BOLERO: INTRODUCING A SELF-HELP GROUP FOR WOMEN WITH BREAST CANCER IN HUNGARY

In 2011, one of the leading oncologists in the Oncology Center of Semmelweis University (prof. Dr. Magdolna Dank), the health psychologist of the department (the author of this paper) and a recovered person who has been symptom-free for several years (Aranka Pataki) founded the “Pink Bolero Self-Help Association against Breast Cancer”. The aim of the group was to provide space for the meetings of patients who are experiencing similar difficulties. The Pink Bolero Self-help Association's self-help group operates as a closed group, but it also welcomes hospitalized inpatients who are interested in the lectures advertised. In group meetings, the health psychologist's task is mainly to help with coherent conversations, to adapt to the topic, and to strengthen group cohesion. On the other hand, her task is to apply various psychosocial methods, to lead relaxation and meditation, as well as to conduct art therapy tasks to relieve fears and anxiety. She actively assists in education, interventions and support. The oncologist herself participates in these informal discussions, this way members can get answers to their questions that they would not be able to ask due to the lack of time in formal consulting hours. With her help, we can also invite other specialists to our group meetings. The role of the recovered founding member is also very important, since she is able to understand the others as a fellow patient, as she has experienced the side effects of various therapies, so she can help competently to alleviate them, and her knowledge of the disease is credible for those who turn to her. Last but not least, her recovery, her years of being free of symptoms and healthy lifestyle can give a positive model and motivation to others. At group meetings, members can experience the acceptance and supportive power of the community – they discuss and reframe individual fears, doubts, or clear up misinformation. An important role in the life of the group is that members can share and shape their own patterns of coping mechanisms.

3.1. HOW THE PINK BOLERO SELF-HELP GROUP WORKS: GROUP PROCESSES

The Oncology Centre hosted the Association for biweekly group sessions. The members (the women affected by the disease) initially joined from among the patients of the university clinic, and then, as soon as the "news" of the group reached other institutions, the participants started coming from various parts of the country, significantly expanding the group membership.

The meetings are organized around the issues of greatest interest to those affected and related to cancer, but the main goal is always to come together joyfully. Group meetings are usually thematic, and the topics are planned in advance by the members at the annual general meeting. According to their ideas, various specialists – such as oncologists, surgeons, radiologists, physicians – as well as other specialists such as dietitians, physiotherapists or stylists are invited. They help, among other things, to choose and wear wigs and replacements correctly, when they are invited to informal discussions. At these meetings, those concerned are free to ask questions that they cannot at the doctor's appointments due to the lack of time. The most important issue is to explore the background of the disease processes and the nature and significance of the different therapies, which can lead to better acceptance. Art therapy, movement therapy and relaxation or meditation exercises are also included in the topics. Art therapy sessions always include an occupation chosen by the members, whether it is mandala painting, beading or making jewelry, but listening to music and discussing various musical works is also popular. Movement therapy is being practiced every time and is always led by a specialist. The members are very fond of tai-chi exercises, these slow movements strengthen balance, stretching helps relieve stress, and under the guidance of a physiotherapist members can learn and practice rehabilitation exercises before and after surgery. Two to three times a year, we invite a gong therapist who conducts an hour-long meditation exercise with the help of sound bowls and gongs.

Members will receive an e-mail reminder of the upcoming topic so that they can prepare their questions. The two leaders of the Pink Bolero Association provide the attendants with fruit, vegetables and mineral water, thus increasing the feeling of "you are important here". The members speak shortly during the first half-hour, a period when new attendants can introduce themselves. This will start a joint communication that establishes mutual trust and increases group co-ordination. The topical program follows during the next part of the afternoon, which ends with 10-15 minutes of movement therapy as a chill-out session. At the end of the meetings, in one final round, we give everyone the opportunity to express their feelings and thoughts about the program of the day and to make suggestions for upcoming occasions.

3.2. PERSONAL EXPERIENCES OF GROUP MEMBERS

Such a paper about the functioning of the breast cancer self-help group would not be complete without presenting the personal experiences of members. We asked the group members – regardless of how long it took to get their first diagnosis and at what stage of the disease they were at – to describe their experiences and impressions in the self-help group and to try to compare them with the support provided by relatives, family and friends. 24 members of the Pink Bolero group[1] undertook to summarize in a few sentences their experiences, changes and achievements that the meetings gave them. Due to the spatial limitations of this paper, it is not possible to publish all the opinions here, but we would like to show some of the most important ideas they describe below, while also trying to introduce the members and their life situations:

3.2.1.

A was diagnosed with breast cancer at the age of 45. She was shocked by the illness and therapeutic options, and as medical events accelerated, so were her husband and her two school-age children. She came to the group following the invitation of a fellow patient. The female patient, who was initially extremely inhibited and anxious, has been a member of the Pink Bolero Association for the third year without interruption. These days, she is the one who "encourages" newcomers. She is currently symptom-free and goes to her doctor every four months for a check-up in order to receive tight monitoring.

"... When I found out I was sick, I was lost, I felt like I had fallen into a very deep hole. There was no one around me who could understand what was going on in my head. My family loved me and flooded me with their love, but they couldn't help me. They didn't have a single sentence for me which I would have believed, I was sick of them trying to make it look like everything was okay, I hated to see them crying. We just couldn't do anything with each other. They made me feel beloved, but I still felt like I was trying to cry for help from a deep hole, help me out, pull me out, I want all this finished, I want to be normal like you, but they just looked down at me from the edge of the hole and just told me to calm down, everything's going to be okay! ... And they didn't understand me. I cried, sometimes I yelled, sometimes I was just quiet, constantly or in waves. And then one day, a friend of mine asked me if I wanted to meet people who had similar problems to mine... She took me to the Association, and I met friends who understood me, who I could believe telling me that I would be cured. Who could answer my questions, my fears, and who immediately and unconditionally accepted me among themselves and surrounded me with their love. I got a lot of spiritual support from Pink Bolero, and I learned to meditate... I became a part of very good conversations, received pieces of useful advice. I'm very grateful to be able to belong here."

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[1] Publishing the members' answers is anonymous, and has been authorized by each group member in a written form.

3.2.2.

B received the diagnosis of a malignant breast tumor at the age of 43. Like *A*, she also had a supportive family background when she arrived at the group. She tried to keep her illness a secret among her colleagues and acquaintances. She sought to address her fears and insecurities by visiting the Self-Help Association.

"... It all started with detecting a bump in my breast and immediately feeling that this wasn't going to be simple... A few days later, I was at the next Pink Bolero gathering. It gave me great strength to have a conversation there without taboos, with people who had proceeded along the path that stood before me just a few weeks, a few months earlier and even with those who had gone all the way several years earlier. They gave me real strength through meeting them, I could see there's life after chemo and surgeries. I received advice, practice, lots of useful information to prepare for chemotherapy, to process hair loss and wig wear. I have been helped to transform the terrifying events that have happened to me for my own benefit, which still determines my self-esteem, my faith in myself, my spiritual strength."

3.2.3.

C was 65 when she joined the Pink Bolero Self-Help Association. Her retirement was about to begin when her mammogram revealed her illness. Her husband, though very supportive from the start, was somehow concerned in an embarrassing way – as she put it. She often felt that her adult daughter, who was mostly trying to gain knowledge from the internet, was almost lecturing her how to go about this disease. She is still undergoing treatment, and still needs radiotherapy after completing chemo, but today she is much more confident and has learned to say "no" to unsolicited suggestions.

"...I summed up in a few sentences what the group provided me and what my family could not give. Listening to these stories will make our own situation more acceptable... we share life coaching advice that we've tried before, making it easier to follow new ideas... Accepting and enduring our destiny requires a lot of patience and perseverance, and the strength of the group is a help in this. ... We cannot speak so openly to the family about anything that happens to us, there are many barriers so that they do not get scared; so as not to worry them; do not sadden them; they don't really know what we're going through; their advice comes from laypeople, they are just guessing. In the group we receive credible information."

3.2.4.

D was diagnosed with breast tumor with bone metastasis at the age of 48. She arrived in the group 18 months ago with a strong fear of death and anxiety. She found it difficult to understand the words of the doctors, the only thing she heard was that her illness would soon enter the final stage. For a long time, she researched treatment alternatives available on the internet, she felt that no one could help her. She could not even deal with the support of her loved ones, and heated arguments became frequent at home. Her bone metastasis is still being treated, but it's completely symptom-free. Breast correction may soon take place, which she is particularly pleased about, as she can regain her lost confidence.

"When you feel like everything is lost because you find out you have breast cancer... there is a group in which there are asymptomatic women or even those in treatment who help each other, with the help of their experience they show that there is a way out, you should not give up the fight... It's a tremendous force, it's a great help to talk about everything. The shared experiences created a community of a lifetime, friendships were formed through the programs together. ... The family helps, loves me, while they are deeply worried... the group provides experience, professional help, and also nurtures the soul. ... It's nice to talk about what's in your brain all the time. This can only be solved in this type of group."

3.2.5.

E was diagnosed with breast cancer at the age of 51 and the disease had already metastasized to her liver. According to her own story, she "let herself go a little bit" after the birth of her two sons. For her, the news of the diagnosis mean that she was facing the end of her life, that is, death. There was doubt about the metastasis tumor removal, and the extra weight caused her heart to be more burdened by chemotherapy. When she joined the group, her self-esteem was low, she lost confidence in herself, she was characterized by self-deprivation. The metastases are gone from her liver, and breast surgery is coming soon.

"What did the Pink Bolero group give me? It showed that you can survive a cancer diagnosis for many years, with a good quality of life. It taught me to rejoice in what I have, to appreciate the beauties and pleasures of life. To take care of my health because there's only one. It started me on a road that led me to lose (so far) 14 kilos, I work out almost every day and enjoy it!"

3.2.6.

F became ill at a very young age, received a diagnosis of breast cancer at the age of 28. She was devastated by the loss of her thick, long hair and the physical and psychological symptoms caused by early menopause. However, participation in the group has very much changed her attitude to the disease. In addition to the treatments, she started working again, continued her studies and became so comfortable with wearing a wig that a photo album of her will be released soon.

"It's a great help to see that your fellow group member is over with what's in front of me... with a lot of advice, you can prepare the others, they tell you what to expect, as it is possible to make the side effects of treatments easier and more bearable... and it is good to see that anyone who has already gone through the treatments is well and living her daily life in the same way she did before."

Based on the above ideas, we can see how self-help group helps the women concerned, and this is noticeably in line with what is described in the literature (i.e. Docherty, 2004; Yaskowich & Stam, 2003). They contain all the specific forms of help that a self-help group can provide in addition to family support. It is extremely important to see that people who share their problem are better able to understand each other, since they know the feelings (pains, fears, etc.) that they talk about it and ask each other questions. Understanding each other, talking in "one language" can help them heal and better understand the thoughts of outsiders and family members about their illness. All of this can help those affected to improve relationships and communication with family and other relatives and friends.

In addition to group support, one of the most important things such a patient community can give is motivation. The realization of what the others could achieve may be achieved by anyone here eventually makes them try. In many cases, we see that those who do better in an exercise try to help and encourage the weaker ones, and that is what gives all of them tremendous strength. Helping each other is an uplifting feeling for both parties – both those who give help and those who receive help – and words of encouragement increase self-esteem.

Those affected are consistently positive about being in a company where there are no taboos, where everyone knows exactly what kind of disease they are coping with. From the examples above, it can be seen that people of all ages experience belonging to the group in a similar way. Perhaps the greatest achievement for a health psychologist is when she can experience that tension and anxiety are dissolved, that hopelessness is replaced by healing; but most of all, the patient's belief in herself that she is able to competently fight the disease. It is very important that during the course of education the patient understands the mechanism of her disease and therapies, by which the adherence increases, the doctor-patient communication develops. As a group leader, it's great recognition that group members love going to Pink Bolero, that they take pride in being a "Pinky girl" („Pinkes lány"), and they can't wait to get back together between meetings. This is the result of finding understanding and attention in the group that they need. It is also an important result of our Association that several people keep in touch outside the sessions, help, support each other, and friendships have developed. Members who have experienced the disease and therapies almost take the newly diagnosed under their "wing" and encourage them to come to the self-help group in view of treatments, to change their relationship to the disease, to strengthen them in body and mind.

A family member (husband) called me once after his partner, who had been previously diagnosed and deemed completely hopeless, returned home from a group meeting: *"… you are doing an incredible job.… never give it up! Thank you so much for getting my wife back."*

3.3. CHALLENGES IN THE LIFE OF GROUPS – DIFFICULTIES IN GROUP MANAGEMENT

The psychologist leading the group feels that her work is effective when the dissolution of anxiety is felt, or when she gets positive feedback. However, more difficult situations may also occur. For example, the presence of someone in the group whose behavior may disturb others may create tension in members. It is important to keep the frames tight and avoid unpleasant situations. Several studies in the literature draw attention to the problems related to the group structure that can disrupt group dynamics and diminish volunteering to join in (e.g. Docherty, 2004; Galinsky & Schopler 1994).

Losing a group member is perhaps the biggest challenge for a team leader. The death of a member, a close acquaintance, brings about painful, difficult emotions in everyone. Death due to a disease of the same type may even become a taboo among group members, as they may have questions that are not based in reality, which may cast doubt on the effectiveness of hard-to-bear therapies and develop a negative view of the future. Tension and anxiety can increase at a time of losing a member. The team leader asks questions about how members will accept the loss of a group member, how it will affect them, how much it will throw them back in terms of treatments or healing, and how this can be resolved in the right way. However, it is important to bear in mind that the emotions of grief should not be suppressed, since unprocessed loss can be a heavy burden for the individual in the future. The Pink Bolero Association, relying on the available literature, developed a common commemoration protocol (e.g. Hajduska, 2010; Zana & Hegedűs, 2009). This stipulates that at a group meeting following such a painful loss, each member can commemorate the deceased in a few sentences, totaling about thirty minutes, and then commemorate the diseased in silence for a minute. It is important for those present to feel that they are not alone in their grief, that they can count on each other, that they can count on each other's support.

4. DISCUSSION

Self-help groups are of paramount importance to patients and their relatives, but their activities are also essential at the societal level, as they support the work of health care institutions and in many cases reduce their burdens.

Group members who responded highlighted "better orientation and professional information" as the practical benefits of patient groups. In this way, they were able to accept their disease, understand the importance of different therapies, and manage side effects. These results are described in several studies and are also mentioned as an advantage for support groups operating in the online space (e.g. van Uden-Kraan, 2008). It was clear from the participants' narratives that loneliness, feeling alone as a psychosocial stressor are often confronted after diagnosis. The results show that even participation in online support groups can help to prevent the effects of this stressor.

The studies also showed that members of self-help groups communicated more easily with medical staff as a result of the sessions, asked their doctors more confidently, and were free to talk to relatives about their condition. A Pink Bolero group member described the development of her communication as follows:

"... I was afraid to ask certain questions from a doctor or a surgeon... I thought I'd had no idea about it anyway, they'd think my questions are stupid, or they'd just turn me down, and besides my troubles, I'd even have to be ashamed... but through the group I learned that I have the right to ask questions, and I need to know what happens to me, what happens to my body. And it was something else, I learned during my studies how important it is. And then I started asking a surgeon about my things, and it was good for me, because I came to understand a lot of things..."

Patients experienced a great improvement in their well-being and in their social relationships as a result of group activities, which reduced their loneliness. Supportive self-help groups were considered by those involved to have provided them with a sense of belonging to a special community and unconditional acceptance. Togetherness helped and facilitated relationships with family and other relatives, friends; their self-esteem and sense of control, their self-efficacy increased, and they felt that they, too, were able to do something for themselves.

Lessons learnt from the self-help groups

In my clinical work, I often help oncology patients by individual support and personalized interventions along their journeys through the disease. Since we founded the Pink Bolero Self-Help Association, I have found that in people who participate in group receptions, tension and anxiety are relieved faster than those attending individual therapies. Since these oncology patients are not anxious at a pathological level or show symptoms of depression, they get rid of those symptoms more quickly when they receive understanding support in a self-help group, whose members have similar problems. The development of group cohesion is important for patients, it gives strength in coping with the disease. Group sessions bring the members together. The role of the health psychologist is extremely important in the cohesion of the group and in the coordination of tasks. The activities of the self-help group, the assistance of patients in this form, and the conversations with the members have also proven to be effective. Patient groups in hospitals and other institutions help patients to process difficult times for them. Connecting to a self-help group is now available to everyone, but this option is still unknown to many in need. I consider it an important task to present the importance of groups in several forums, in institutional newspapers, in the media, even in health programmes, and to explain their activities. In addition, I believe that there is a great need for more groups representing other specific areas, so that this form of support, self-help, can reach everyone.

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PSYCHOLOGICAL CARE FOR MEDICAL STUDENTS

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1. INTRODUCTION

Our job involves the psychological care of foreign and Hungarian medical students. Below, we introduce our experience and the relevant literature. There are complex factors underlying the stress experienced by medical students in relation to their studies (Pikó, 2014). The demand of mastering an extensive curriculum is directly linked to personal sacrifices. Additionally, students are exposed to a highly competitive and tense work environment. Epidemiological data on mental health has shown that more than 20% of medical students suffer from psychological disturbance and/or show mental health problems (Thun-Hohenstein et al., 2020). The amount of medical knowledge has been doubling every 73 days since 2010 based on estimations from 2018 (Corish, 2018). New medical knowledge gradually gets incorporated into the curriculum, constantly adding more to the knowledge required to finish medical school successfully. Demands placed on medical students (which often seem impossible to meet) further increased in 2020 due to the COVID-19 pandemic. The stressors commonly experienced by medical students may contribute to developing burnout, depression, and anxiety.

To prevent anxiety and depression, we often use relaxation techniques (Stetter & Kupper, 2002) and put lifestyle factors (such as the daily amount of sleep and general health status) in the focus of counseling. These techniques significantly influence the development of depression and anxiety (Cheung & Yip, 2015; Hoying et al., 2020). There is also a link between health beliefs and behavior and the development of depression and anxiety (Hoying et al., 2020). Our experience suggests that education on a healthy lifestyle may itself induce changes in the students' representations of themselves and their health.

Social support is the most common coping strategy among medical students (Steiner-Hofbauer & Holzinger, 2020). However, social support seems to reduce depressive symptoms only if it meets the exact needs of the recipient (Haldorsen et al., 2014). Medical students wish to receive social support specifically from their university (Dyrbye et al., 2010), and through the psychological aid provided by the university counseling staff, significant improvements can be achieved.

Some medical students may turn to maladaptive coping strategies such as alcohol or drug use to reduce their depressive symptoms and anxiety (Keller et al., 2007; Newbury-Birch et al., 2001). One can assume that given their profession and high level of health literacy, medical students have a lower risk to develop addictions; however, in reality, this does not seem to be the case (Gignon et al., 2015). Both our experience and empirical research suggest that not only alcohol and illicit drug use but excessive caffeine intake (in the form of energy drinks or coffee) may also occur in medical students. Caffeine also has a health-harming effect if consumed too often or in large amounts (Sawah et al., 2015).

It is also important to note that maladaptive coping strategies may not only result in mood disorders but also psychosomatic symptoms. The most common symptoms include fatigue, sleep disturbances as well as upper and lower back pain (Pikó, 2014). In female medical students, psychosomatic symptoms also include menstruation disorders such as dysmenorrhea and PMS (premenstrual syndrome) (Kanti et al., 2020).

We regularly encounter medical students who ask for help because they are procrastinating tasks related to their education and cannot finish them on time despite being aware of the potential negative consequences (e.g., deteriorating learning outcomes due to being unprepared). Procrastination of study-related tasks is independent from the cognitive skills of the student; however, it is linked to negative emotions (including anxiety and depression) towards the task (Huszár & Huszár, 2014). Furthermore, procrastination is also related to self-control, perfectionism, fear of failure, and irrational expectations (Huszár & Huszár, 2014; Steel, 2007). With respect to self-control, internet addiction should also be mentioned (Hayat et al., 2020). Perfectionism is one of the most prevalent personality traits of medical students and refers to high expectations towards oneself (Enns et al., 2001). Basically, to provide meaningful help to the students trapped in the vicious circle of procrastination, we need to explore the causal relationships underlying their behavior.

We share the conviction of researchers and we believe that offering psychological counseling and an opportunity to acquire new stress management techniques is a way of preventing burnout syndrome, depression, and other mental health disorders among students (Iqbal et al., 2020). During the counseling process, students learn healthy coping strategies, which may lead to greatly improved quality of life, healthy development of professional identity, and prevention of mental health disorders.

2. CASE REPORTS

The cases introduced here are fictional stories based on several similar cases from our counseling work with medical students. All personal data of real clients, including name, age, and ethnicity, have been changed to respect the clients' personal rights. The first case report is based on the counseling experience of Eszter Racs and the second on the experience of Nelli Fischer.

2.1. THE CASE OF ZACK *"IF I TAKE A BREAK, IT'S ALL OVER"*

When he contacted me, Zack was a barely 20-year-old third-year medical student desperate for immediate help. He was extremely concerned as he did not feel good neither mentally nor physically; he could not concentrate on studying for weeks. Previously, he never had any problem with studying and was a cheerful and energetic person. As I noticed, precisely this was that had shocked him (and his environment) the most. How and why would such a young man feel bad while normally he is easy to connect with, has above-average abilities, and records outstanding performance?

Zack was so desperate when he called me that he wanted instant relief from his feelings. Although our short conversation upon making an appointment gave him a bit of relief, his voice still felt disappointed at the end of the call. He wanted me to immediately tell him what to do and what decision to make: should he take a semester off or not? It occurred to me that he wanted permission to rest but also that he might have wanted me to motivate him to continue. I was feeling all kinds of emotions and was unsure if I would be able to help him in a relatively short counseling process with 5 to 10 sessions. At this point, I had not expected that he would suffer another loss in the form of losing his grandmother in the middle of the counseling process.

2.1.1. First interview

Less than one week had passed between our first contact and the first interview. Zack arrived with a decision he had already made, that he would take a semester off. He wanted to focus on his mental and physical health and to travel home to his family who lived on another continent. He had not seen them for more than a year by that time. However, setting these goals came with guilt. If he prioritized his health over his studies, others would be disappointed in him, and he would also disappoint others which seemed unacceptable for him. He asked for help to cope with the disappointment.

Zack arrived in Hungary after finishing secondary school to begin his studies as a medical student. At the time, he was barely 18. Since his arrival, he visited home only once. Before moving to Hungary, he used to live with his parents who are also doctors, and worked hard all their lives. Despite the great physical distance, Zack had a strong connection with his parents and often talked to them. Already in the first interview, Zack mentioned that his father had developed chronic back pain a few years ago and that his symptoms became more frequent and intense. Just before Zack's first interview, his father's symptoms had worsened, which visibly shook Zack. It was clear that the family is extremely important for Zack, hence the eagerness to finally see his relatives again when returning home, even though he could not meet his brother, who studied abroad at a university just like Zack himself.

His parents and previous teachers always believed in Zack; however, they also had high expectations towards him. He was an eminent student in primary and secondary school, and this continued in his first two years at the university. As a second-year medical student, he already took part in the education of first-year students.

He spoke in more detail about how passionately he studied and had an interest in many things and had known that he wanted to be a doctor since he was young. He also talked about the various learning methods he used. It became clear that his current mental state did not originate from a lack of learning methods or commitment to the medical profession.

Zack also shared with me some traumatic events from the past year which had affected him emotionally. One of his close friends had committed suicide, and his father had been unwell almost all year and had to undergo surgery.

Before his current state, Zack was the one to support and motivate others, for instance, his father. He was even able to beat the distance of thousands of kilometers and organized online events aiming to improve his father's health. Therefore, it was especially hard for Zack that he could not motivate himself, let alone others. He reported that his current state had started approximately two and a half months before we met and was characterized by a lack of motivation to study and feelings of listlessness and being drained. One and a half months ago, upon hearing that his father's back pain had exacerbated, Zack's state had further deteriorated as well. Meanwhile, he had distanced himself from his friends and got disappointed in many of them. He felt like he had *"no one to rely on at the moment"*. We contracted for five more sessions. We later changed it to eight sessions as a result of an acute grief process. The goal we set was to reconcile him with his decision (i.e., to take a semester off). We met three times in person and five times online via web camera consultation.

2.1.2. Health and Illness Representations

As Zack noticed that he was turning more depressive, exhausted, and listless, he started to blame himself: *"I despise myself for feeling like this, I should feel okay."* He painted himself as lazy and do-nothing, as if he did not have very real problems to deal with. He kept repeating that he did not know how he reached that point at which he felt so drained, and was unable to improve his situation on his own. He could think of his current state and decision to take a gap semester solely as a loss. Moreover, he was unable to identify with the feeling of this loss: *"I'm giving up right now, and I am not myself whenever I give up."* Zack also explained that in his family, they were not used to expressing negative and unpleasant feelings and mention bodily pain. His father also hid his pain until it was already unbearable. According to his parents, psychological issues were *"not real problems."* Thus, Zack followed the pattern and endured the loss of motivation, the exhaustion, and the listlessness that lasted for weeks, and he was angry with himself for not being able to study and getting along with his friends as well as before.

2.1.3. Methods

Zack filled out the Maslach Burnout Inventory–Student Survey (Schaufeli et al., 2002) and received psychoeducation on the cognitive model (Beck, 1963). We worked with his negative automatic thoughts. Zack wrote a thought diary with which he could monitor not only his thoughts but also his emotional, physical, and behavioral responses. With this practice, we were able to identify the dysfunctional attitudes and beliefs underlying the negative automatic thoughts.

I used OH Cards (France & Lawrence, 1993) as well, because Zack also shared with me that he loved art and had a creative side. Zack loved the OH Cards so much that we worked with one or two cards for at least a few minutes in almost every session. Zack found it easy to project his story onto the cards. This way, he had an opportunity to symbolically process what he was going through.

2.1.4. Resources and Coping Strategies

Zack lived in an extensive social network in which he, at the time, could not rely on. His openness and curious nature made him easy to work with. He enjoyed doing his homework and asked several relevant questions during the counseling process. Furthermore, his creativity aided the work with the OH cards.

Zack said that previously he was getting by with the denial and repression of negative thoughts and the forceful replacement of these thoughts with positive ones. He always repeated what his father said to him: *"Stay positive!"* As Zack thought of himself: *"I'm the strong one in the family."* Also: *"I'm only valuable if I bring joy to others, and I stay positive."* Coping mechanisms like repression and emotion replacement seemingly worked for him in the past; however, they did not work in the present situation. Moreover, since he neither felt strong nor positive, he ceased feeling worthy which worsened his state.

Concerning his social connections, conflict avoidance was also present as a coping mechanism since he had often hid his feelings from his friends when he had been being hurt. As he formulated it: *"I don't care if someone hurts me. I don't say anything. I'm the one who supports others, who listens and can give advice."* By the end of the counseling process, the repression of negative thoughts was replaced by acceptance *("It's all right if I don't feel good.").* Moreover, instead of hiding his emotions and feelings, emotion regulation was increasingly practiced *("I told him that I was hurt by him not telling me the truth.").*

2.1.5. Social Support

Although Zack was supported his entire life by both his friends and family, they secretly conveyed the message to him: *"You should remain positive all the time."* This created a compulsion to conform. If someone always stays positive and happy, it means that the person is not allowed to feel bad and be disappointed or sad. Zack, but also his environment needed time to get used to the fact that Zack could feel bad and that it did not make him a different person. The decision Zack made was immediately received with empathy by several of his loved ones (although some still suggested he should remain positive and keep fighting because taking a semester off equals giving up and losing).

2.1.6. Communication Skills and Health Literacy

Zack appeared to be a talkative and honest person who (although he stated that he is not used to talking about his feelings) described his emotions in a nuanced manner: *"I felt drained," "I despised myself," "I felt like a burden to others."* He never described his complex feelings with only one word: *"I am overwhelmed and disappointed," "I feel relieved but also scared."*

Although the extremely talkative personality of Zack made the counseling easier, sometimes he lost himself in talking and it was hard to stop him from having one long monologue in half of the session so that we could also work together. We could discuss this and after he became aware of this tendency, he tried to express himself more concisely while keeping eye contact so he could monitor my reactions.

The client himself put it into words in the first session that he did not want "the situation to go south." Thus, it was straightforward that he was worried about his complaints even if he could not identify their root cause. During the counseling, he quickly understood the link between the physical and mental symptoms, just like the function of different homework tasks. The high health literacy of Zack enabled a dynamic counseling process to take place.

In his family, it was unusual to express emotions or bodily sensations; however, they formed a cohesive, caring, and accepting community. The family respected Zack's decision to take a semester off, and he was welcomed home again, allowing him to rest. This facilitated the counseling process considering that Zack connected to the session online from his family home after the third in-person session until the end of counseling.

2.1.7. Interventions and Their Goals

Zack filled out the Maslach Burnout Inventory. His results on the Emotional Exhaustion and Personal Accomplishment subscales called for attention. His score on the Depersonalization subscale was insignificantly low; being impersonal or cynical was not characteristic to him. The discussion and psychoeducation following the completion of the questionnaire revealed to Zack that having mental blockages (such as being in a near burnout stage) can be real and can hinder his performance in all aspects of life, not to mention the consequences on his health.

The thought diaries aimed to give Zack an overview of what thoughts maintain his current unfavorable state and how. They also helped him to see how these thoughts are connected to his bodily sensations, emotions, and behavior. Moreover, we observed where these thoughts and emotions originated from and what previous situations had brought them about. Early in the counseling process, specifically, on the second session, Zack mentioned that he felt as if particular members of his family, but not his parents had withdrawn their love from him because of his decision to take a semester off. This was hard to accept for both Zack and the family because they thought of it as an untypical decision by Zack, which resulted in negative automatic thoughts in Zack. *"I should have tried harder." "I should have been stronger." "It would be better if I didn't exist at all." "I'm a burden to others."*

Dysfunctional attitudes also emerged: *"If I tell others and openly express that I feel bad, I'm just burdening them." "I'm not worth anything if I cannot stay positive." "If I cannot perform outstandingly, there's no point in me existing."* Some deeper, more general beliefs were also present, such as: *"I'm a failure." "I'm a disappointment."*

Zack linked these beliefs mainly to his previous school experiences. The same thoughts arose years ago when he also had had to fulfil a number of expectations. Once during a competition, one of his teachers introduced him to the audience as the best and most prominent student of the school who would win the competition. This triggered thoughts similar to those mentioned above and even caused him to freeze for a little.

The examination and questioning of negative thoughts first occurred in the form of negations: *"Maybe I couldn't do more this time." "Maybe I'm not a burden for others, not even in this state." "It's not necessarily a failure to take a gap semester as I plan to continue my studies."*

These thoughts gradually transformed into assertive sentences: *"What I do and who I am is just enough." "My decision has also brought many new things in my life."*

The questioning of negative thoughts not only aimed to facilitate the change of the narrative thought but also to influence the emotional and behavioral responses. Zack's initial emotions (mainly dominated by fear, exhaustion, hopelessness, and guilt) gradually got replaced by the sense of relief and motivation. His initial behavioral responses were driven by conflict-avoidance and avoidance stemming from the compulsion to conform. On the other hand, in the second half of the counseling process, he reported expressing his feelings towards others with an increasing frequency. He was also able to give space to his negative emotions during a grief process he incurred, which allowed him not to get stuck in his feelings. During the period of the last few sessions, he started participating in an internship, of which he gave very positive feedback.

The aim of interventions with the OH cards (sentence forming with given words and storytelling) was to symbolically represent his own narrative. The sentences and stories Zack created expressed his current mental state and level of acceptance regarding his decisions. He linked the main characters of the stories to himself and even incorporated the counseling work in one of his stories. Putting Zack's stories in order can demonstrate how he got closer and closer to accepting him taking a gap semester and how his decision gradually got integrated into his personality.

2.1.8. Terminating of the Counseling Relationship

Getting close to the termination session, Zack reported the effects of having his thoughts and behavioral patterns become more conscious without me having to ask him about it: *"I think I shouldn't have overexerted myself. I see my parents and how much they work, and I respect them very much for it, but they haven't spent time with me since I came home. I feel like my father's illnesses are related to working constantly. I want to continue my studies and become a doctor, but I wish to proceed without sacrificing myself, my social life, and my health. I would like to express whenever I am feeling bad, cry if I am sad, even if I'm told not to cry."*

Zack was unsure about ending the counseling process and wanted to make sure that he could return to me if he felt stuck. However, in our last session, he also expressed that he was ready to use the techniques he learned on his own and continue his studies in the upcoming semester.

Lessons learnt this case

Zack's case reminded me that I have to pay attention to keeping the appropriate therapeutic frames even if a client approaches me in despair (for example, offering an appointment right away is usually not possible). The case reminded me of the benefits of not slipping into the trap of giving direct advice and prompting independent decision making from the beginning to the students who approach me. This way, the therapeutic work can start even before the first interview.

2.2. MAXIMA'S CASE "IT'S WORTH A TRY."

Maxima asked for an appointment on the phone and stressed right away that her friends had made her contact me. By her own admission, she only believed in medical sciences, but added: *"it's worth a try."* This call for an appointment invoked my professional self. I felt like I needed to prove that I can provide actual help.

2.2.1. First Interview

Maxima was a fourth-year medical student in her early twenties. Both her parents had college degrees; hence, according to her, *"it was never in doubt"* whether she would go to university after finishing secondary school. Her parents divorced years ago. She lived with her mother but met her father weekly, so he was still very much part of her life.

She said that the divorce had not been a loss only: she got to celebrate every holiday twice, with her mother and father separately.

She approached me because the last exam period exhausted her. She lost her motivation and felt sick to the stomach from the thought of getting back to studying, even before the semester started. She had a hard time during all her previous exam periods; she got exhausted both physically and mentally. She reported weight loss in exam periods because she could not eat as her stomach was in spasms. She had even thrown up on the day of the exam repeatedly. These complaints were accompanied by lower back pain and stomach cramps. She visited her family doctor with these symptoms and got painkillers prescribed. However, her symptoms returned from year to year and did not dissolve. Even her family doctor remarked that *"there may be something stress-related behind these complaints."* However, Maxima did not feel like she had time to begin dealing with her symptoms as she was so busy studying. She felt like talking about her symptoms would only be a waste of time. I reiterated that in our phone call, she had referred to her friends as a motivation to contact me. To my question about why she asked for help, she said that she felt like there was nothing to lose. Since her family doctor also supported this, *"there might be something to it."* She searched my eyes during the whole session as if she wanted to find out why I asked the things I asked. I had a feeling that my client was testing me.

Maxima also reported that due to the challenging exams, she gradually lost the self-confidence she used to have when she had started the university. She thought of herself as a bad examinee, afraid to talk not to say something stupid. She feared that the professor would humiliate her in front of the other students. Only the highest grade was acceptable for her; anything less was deemed a failure. She often experienced nightmares during the exam periods. These nightmares were always related to the exams.

We contracted for five more sessions with the aim of stress management and the improvement of her coping. Maxima put it into words as follows: *"I'd like to take control because now I feel like everything's getting out of hand."*

2.2.2. Resources

Thanks to her curious nature, Maxima's initial resistance was replaced by curiosity. The good student she was, she prepared all her homework, and by the last few sessions, she even started to enjoy doing them. Despite the challenges, she viewed herself as a positive person, always trusting that *"things get better if we do everything we can."*

Her parents supported her in everything. She had a deep, trusting relationship with her mother. Although Maxima usually did not tell her if something bothered her, but she called her in these cases. Her mother's understanding attitude usually had a calming effect on her.

An important resource of Maxima was her altruism. She was keen to help others. Her friends could always rely on her and vice versa. She only had a few friends, but those friends had been by her side for years and they shared a strong bond. She said that her trust in herself helped her to overcome all obstacles, *"whatever it takes."* By relying on these factors, she was able to overcome the challenges she had to face.

Listening to her talking, I felt that what she said was contradictory to what she currently experienced. When she first contacted me, the things she previously had enjoyed could not fill her with joy (apart from studying, she also liked reading or spending time with friends). It seemed like she wanted to put herself in a better light in my eyes.

2.2.3. Methods

I asked her to write a stress diary. She was excited to write down her experiences and the negative automatic thoughts, which we would discuss later. I encouraged her to write down the positive events also because I noticed that her thinking was narrowed to the negative events which needed to be overcome. She could not recognize how many positive things happened to her in her everyday life.

I used OH Cards (France & Lawrence, 1993) to explore her resources. I was surprised to see that she linked her resources to some cards onto which most clients project negative content. This shed light to the internal coping skills of Maxima.

2.2.4. Health and Illness Representations, Coping Mechanisms

In stressful situations, the client developed physical symptoms affecting the digestive system. To my question regarding what were the things in her life that she could not digest her answer was as follows: *"I really would like to meet everyone's needs, but I know with my brain that it is impossible. Still, I try because I cannot fail."* She mentioned that she remembers from her childhood when she had brought home a C grade. Her parents scolded her severely. They got divorced the same year. Since then, she felt like she could not allow herself to perform poorly. She learned that poor performance is associated with disapproval which is accompanied by shame.

She said that her experience of the divorce was not negative, the news of it she was told in a rather factual manner. She never saw her mother being sad, and according to Maxima, her mother *"didn't have time to cry"* at the time of the divorce. Maxima displayed a similar dynamics. Although she talked to her mother about her feelings, she often held these feelings back in order not to be a burden for her. Maxima, like her mother, did not have time to deal with her own emotions. Consequently, she felt like she lost control over her emotions and her body.

The coping of Maxima fit well into the model of Self-Regulation by Leventhal and colleagues (1980). For Maxima, the exam period was a threatening external stimulus, while her physical symptoms (such as stomach cramps and lower back pain) can be categorized as internal stimuli. She believed that her symptoms had underlying somatic causes; hence, she approached her family doctor. All this induced more anxiety and worries in her.

Seeking the doctor's help indicates problem-focused coping. In contrast, when relying on emotion-focused coping to regulate her emotional state, she denied having mental problems and managed her anxiety by drinking alcohol. Often, she was afraid of an exam so much that she postponed the exam date but did not spend extra time studying for the exam. Instead, she avoided facing the situation and escaped from it. When she eventually made an evaluation, she concluded that when the exam period was over, her symptoms were also gone, so she did not feel the need to change anything. In the following exam period, she could rely on her previous methods of coping again. However, this started a vicious circle. Additionally, she looked for social support and spent time with her friends in parallel with alcohol consumption. She viewed her difficulties as challenges which indicated that search for positive meaning was typical of her.

2.2.5. Social Support

The client could count on her friends and sought their company even in difficult times Although she shared her feelings with her mother as well, she kept her negative thoughts and the details of her unmotivated state to herself. She missed a partner in her current life with whom she could share everything. The only motivation Maxima had for the upcoming semester was her hope to get romantically engaged. She said referring to her previous relationship: *"I know how good it is to have someone. Anything can be achieved together."*

2.2.6. Communication Skills and Challenges

Maxima was a talkative girl with a normal speech rate. Instead of talking about herself, she often relied on commonplaces and spoke about people in general. *"Others have difficulties, too." "It's important to achieve something in your life."* This could have been partly due to the fact that she was afraid of being judged for how she would express herself. *"You must think now that this is silly." "You must be thinking that I shouldn't have said that."* Therefore, the emotions of the client were hard to approach for me, as well. The projective properties of the OH Cards helped to overcome this barrier. A sense of security later replaced the initial hesitancy, and the client was gradually able to open up more during the sessions.

2.2.7. Health Literacy and Family Environment

Maxima initially denied a link between her physical symptoms and mental state. With the progress of the counseling and the help of the stress diary, she realized the patterns in her reactions to stressful situations, also the connection between her physical and mental symptoms.

The parents of the client kept a good relationship with each other despite the divorce. Thus, they provided a secure family background to Maxima, although living in different households. She regularly kept in touch with her father despite living separately. She could rely on him in every way; however, their conversations were limited to the topic of her studies at university. The situation was similar with her mother as she was sometimes afraid to share her feelings with her.

2.2.8. Aim of the Intervention, the Therapeutic Process

The OH Cards helped to unravel the internal resources of the client of which she had forgotten lately. She was surprised by her own associations seeing the cards. She realized that previously she had been thinking more positively and her thougths were especially negative with respect to her studies. When the exam period came nearer, her emotional state got worse and worse. *"This is like a downward spiral. Once it starts, things can only go downwards."*

Maxima felt like she was losing her confidence. She wished to be able to trust her abilities more. According to her environment, she was always someone to rely on, and she could always overcome the difficulties. She then realized that others think she could overcome the *"bad things"* during her studies because of her motivation in life to help others.

As a homework, she was asked to write a diary on positive events. She commented the following on this: *"It was nice to write down these at the end of the day. It reminded me of my old self."*

Although the task was given for only one week, Maxima liked it so much that she continued to write down the positive events until the termination of the therapeutic process.

With the help of the stress diary, she realized her behavior patterns when the exams started to approach. She identified the triggers (e.g., the posts of other students on Facebook who had already finished an exam) and the signs of stress (e.g., loss of appetite, sleep disturbances). She then learned to change her reactions. For example, she incorporated exercise into her everyday life. Therefore, she got tired not only mentally but also physically. She also stopped taking naps during the day so she could sleep better at night.

Her procrastination of study-related responsibilities always started with postponing the date of the exam. I asked her to write arguments for and against postponing when such thoughts appeared. Whatever decision she made, she was encouraged to put positive motivating messages somewhere in her room where she could regularly see them. The initially negative messages *("I do not want to fail")* later became positive *("I can do it").*

We practiced progressive relaxation from the repertoire of stress management techniques. Maxima initially said that she was *"unsure about what to feel."* However, following at-home practice, she reported positive changes, especially after the evening practices: *"I wouldn't have thought that I could ever fall asleep this fast with the exams approaching."* The client also reported that due to the stress, her posture became hunched during the exams, which she thought made a negative impression on others. *"I curl up, I am sure they can see how terrified I am."*

Later, she exercised rapid progressive relaxation before one of her exams which was of great help to her: *"It was such a good feeling. Usually, panic takes over me, but I did not let it happen this time."* The client also drew a life path diagram. She marked the important positive and negative life events on an axis, and she was asked to leave space for the future on the diagram. She commented: *"It was nice to talk about the future. I would've never imagined being so close to it."* The life path diagram demonstrated that Maxima had emotional scars from school about which she had forgotten. Her peers ridiculed her in second grade when she was hadn't won anything in a spelling contest. After making these incidents conscious, she was able to reframe her negative experiences of the exam: *"Now I have the opportunity to change them."* She recognized that concerning her studies, she felt a strong compulsion to conform towards her parents. This feeling was stronger in association to her father. According to the client, he was the one who asked her the most about the university: *"We don't have anything else in common, I don't know what else we should talk about."*

Though initially skeptical, Maxima started to open up and trust in me during the course of the counseling. The good student she was, she prepared all her homework to comply with what I'd told her, but eventually she started to enjoy doing it. A liberating feeling replaced her severe compulsion to conform. As she formulated it: *"I can feel the change. I can enjoy the smaller things. I think I've become more resistant to difficulties. It may sound arrogant, but I'm happy that I came here because I couldn't have achieved this alone."*

Lessons learnt from this case

During the work with Maxima, I felt like I had to meet her expectations as if she had been testing me every session. In between two sessions, I was carefully selecting tasks to achieve as much of a striking result with as high effectiveness as possible. I realized that these feelings were hers too, as having a compulsion to conform was strongly characteristic to her, and during exam periods, she was fixated on the exams. Through all this, I have recognized how important self-reflection is. It is not the magic that matters but the whole therapeutic process.

3. DISCUSSION

Although we have thoroughly discussed the negative effects of stress to which medical students are frequently exposed, we need to emphasize that stress in itself does not cause depression and anxiety in all the cases. The relationship to stress is more important along with the response given to stressors. Both research studies and our own experience (Haldorsen et al., 2014) suggest that these are the factors that make students more prone to depression, anxiety, and mental disorders. Zong and colleagues (2010) have proven the importance of medical students acquiring adaptive coping skills during their university studies. This is because depression and anxiety are built on maladaptive coping mechanisms. Furthermore, if new adaptive coping strategies replace the maladaptive ones, the likelihood of developing mental health disorders decreases.

Both case reports highlight that, by the end of the counseling process, the maladaptive coping strategies of the clients were overwritten by adaptive coping strategies. Making the emotions conscious and processing them facilitated the replacement of maladaptive coping strategies. During both counseling processes, the family background of the clients had been brought to the fore. Family background has an important role in what attitudes clients have regarding emotions and in stress coping.

Notably, medical students rarely hear about emotions and the psychogenic aspects of health and illness during their studies, primarily representing a somatogenic approach. Therefore, emotional self-reflection is especially challenging for them. Medical students also need to meet high expectations and take great responsibility. Thus, the stressors that also await them in the future are present early in their training. As a result, it is easy for the students to experience burnout or near burnout stages, just like the clients in the cases presented above. This may hinder the students' advancement at the university. However, psychological counseling provides help to resume their studies with success, having acquired new knowledge and skills.

Zack thanked the counseling work in a letter in which he described how he had been and what feedback he received from others since the termination of the counseling. He expressed that he was already preparing for the next school year, excitedly looking forward to continuing his studies. We believe that the feedback from students is the best proof of the relevance of the counseling work in preventing and screening mental health disorders.

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THE WORK OF THE CLINICAL PSYCHOLOGIST WITH PHYSICALLY ILL PATIENTS

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This chapter aims to provide an insight into the work of clinical psychologists working in somatic care. First, the complex interrelations between physical and mental illnesses will be reviewed, followed by a discussion of the most common comorbid mental disorders (depression, anxiety) and their complex effects in relation to chronic physical illnesses. Effective management of the complex interrelationship between body and mind also requires complex, integrated health care for people with physical illnesses who also have mental health problems. This requires a multi-disciplinary approach and work, of which liaison psychiatry is a significant example. An important member of the treatment team is the clinical psychologist, who supports somatic patients in collaboration with representatives of other disciplines, including health psychology. The remainder of this chapter focuses on his or her work and experience through case studies.

1. PHYSICAL AND/OR MENTAL ILLNESS

1.1. THE COMPLEX RELATIONSHIP BETWEEN PHYSICAL AND MENTAL ILLNESS

According to the biopsychosocial approach currently prevailing in health science, biological (genetic, hormonal), psychological (thinking, feelings, behaviors) and social (socioeconomic, environmental, and cultural) factors contribute to the pathogenesis, persistence, or prognosis of diseases (Wade & Halligan, 2017). The relationship between physical and mental illnesses is bidirectional: some chronic somatic conditions can elevate the risk of mental disorders, and mental disorders can affect health status, treatment, and outcomes (Prince et al., 2007).

1.2. CHRONIC PHYSICAL ILLNESSES AND COMORBID MENTAL DISORDERS

Among people with chronic illness, the most common mental disorders are depression (two to three times more common than in the general population; National Institute for Health and Care Excellence [NICE], 2009) and anxiety (with similar prevalence; Kariuki-Nyuthe & Stein, 2015; Scott et al., 2007). Some physical symptoms – such as sleep disturbance, loss of appetite, lack of energy, fatigue, weight loss – may be a consequence of illness or treatment (e.g. steroids), may be interpreted as a natural response to a diagnosis of chronic physical illness, or may be signs of depression. Functional limitation brought on by persistent illness may also result in distress. This can make co-occurring mental illnesses more difficult to recognize, although they are associated with a number of serious consequences, including poorer clinical outcomes and quality of life, less effective management of physical symptoms (Benton et al., 2007; Katon, 2003; Vamos et al., 2009), repeated hospitalizations (Jiang et al., 2001), increased treatment costs, and lower employment and productivity (Hutter et al., 2010).

1.3. CO-MANAGEMENT OF PHYSICAL AND COMORBID MENTAL ILLNESS

Effective support for the mental health needs of people with chronic illnesses can, however, improve both mental and physical health. Despite this, mental health care is often lacking from health care. Moreover, different departments (e.g. mental, somatic and social care) are often separate, so that patients may get stuck in gaps between services.

1.3.1. The Nature of and the Need for Integrated Health Care

Integrated health care is the only way to overcome the above-mentioned difficulties and shortcomings. It is a unique approach in which different professionals (doctor, nurse, dietician, physiotherapist, psychologists with different specializations, social worker, etc.) share information and develop a comprehensive treatment plan (APA) based on the biological, psychological and social needs of the patient. Integrated health care is a way of putting the biopsychosocial model into practice, and is particularly important in the care of people with long-term illness, those with medically unexplained physical symptoms (e.g. chronic pain or fatigue), or those requiring immediate care for combined health problems (e.g. delirium, somatic manifestations of eating disorders, etc.) (Prince et al., 2007).

1.3.2. Liaison Psychiatry in Integrated Health Care

An important example of integrated health care is liaison psychiatry, which most often involves acute psychiatric care, but is also available in specialist hospitals and primary care for the treatment of a variety of mental health problems (e.g. self-harm, dementia, alcohol and drug abuse, behavioral disorders). Liaison psychiatry can be implemented in a *consultation model* (requesting a council) or in an *integrated model* where the liaison team is involved as part of the medical staff in care, for example in pain clinics, oncology, or geriatric wards (Stevens & Rodin, 2011).

1.4. ROLE OF THE CLINICAL PSYCHOLOGIST IN SOMATIC CARE

The integration of the work of the clinical psychologist into multidisciplinary health care is essential for several reasons:

I. through diagnostic work, he or she addresses the biological, psychological and social aspects of the illness, thus helping to improve access to quality care and reduce the cost of care;
II. facilitates smooth communication and collaboration between colleagues;
III. ensures that the patient has access to all necessary treatments, including the most effective ones, and helps to stimulate motivation to recover;
IV. alleviates anxiety and stress related to the illness, allows the prevention of depression, and thus has an overall positive impact on treatment (Azad & Mahmud, 2014; Wahass, 2005).

Psychologists working in somatic care can be involved in both inpatient and outpatient care. Although the profile and focus of physical treatment may vary depending on the disease group (e.g. dermatology vs. surgery), the work of clinical psychologists always involves mental health assessment and diagnosis, as well as psychological interventions. The assessment of the condition involves a review of the patient's or the illnesses profile and possible treatment goals (Vincze & Perczel-Forintos, 2019). The aim of psychodiagnostics is to establish the correct diagnosis, answer differential diagnostic questions, accurately identify comorbid mental disorders (e.g. depression, anxiety, substance abuse, cognitive decline, somatization, illness anxiety), and assess suicidal vulnerability. Questionnaires and tests will be administered, which will allow for follow-up in later stages of treatment. The most commonly used instruments and procedures for assessment and psychodiagnosis are listed in Table 1.

Table 1 Instruments and procedures used in diagnostic and assessment work

Beck Depression Inventory (Beck et al., 1961), Zung Self-Rating Depression Scale (Zung, 1965)
Hopelessness Scale (Beck et al., 1974)
Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983)
Beck Anxiety Inventory (Beck et al., 1988), Spielberger's State Trait Anxiety Inventory (Spielberger et al., 1970)
Short Health Anxiety Inventory (Salkovskis et al., 2002)
Fear of Negative Evaluation Scale (Watson & Friend, 1969)
Dysfunctional Attitude Scale (Weissman, 1979)
Cognitive Emotion Regulation Questionnaire (Garnefski & Kraaij, 2007)
SCID -5-CV Structured Clinical Interview (First et al., 2018), Motivational Interview (Miller & Rollnick, 1991)
Projective techniques: e.g. Rorschach test, drawing tests
Others: disease specific questionnaires e.g. Dermatological Quality of Life Index (Finlay & Khan, 1994)

So-called *low-intensity psychological interventions* are forms of care that provide effective but minimal intervention for mild to moderate mental health problems, often in the form of self-help books, internet-based programs, short telephone consultations, thereby increasing accessibility, flexibility and cost-effectiveness of treatment (Bennett-Levy et al., 2010). They are highly adaptable to somatic care, as they can be easily adapted to different forms of care (inpatient, outpatient) and to the changing complexity and severity of patients' needs and illnesses (Purebl, 2018; Vincze & Perczel-Forintos, 2019). In addition, psychologists can support patients' recovery through a variety of interventions, such as cognitive behavioral therapy, relaxation, supportive therapy, interpersonal therapy, crisis intervention and group therapy, according to their professional and methodological qualifications. The interventions aim to promote behavior change, improve patient cooperation (diet, exercise), adaptive coping strategies, helping the patient to adapt to the new way of life caused by the illness, relieving the tension, stress and anxiety associated with the trauma of the illness, and treating comorbid mental disorders (depression). The psychological tasks vary at different stages of the disease. For example, during prehabilitation (preparation for surgery), functional capacity, coping and support for relatives are the primary focus; during the progression of the disease, addressing adherence problems, psychoeducation, stress reduction are emphasized, and terminal conditions also require a different focus (e.g. addressing pain and helplessness) (Azad & Mahmud, 2014). The psychologist can also facilitate doctor–patient communication and the achievement of an effective partnership in treatment.

Table 2. The patient's psychodiagnostic test scores before (objectively BPPV-free) and after psychological treatment

Scale/name of inventory	*Scores before treatment*	*Scores after treatment*
Dizziness Handicap Inventory (Jacobson & Newman, 1990; Szirmai et al., 2018)	58	26
Beck Anxiety Inventory (BAI) (Beck et al., 1988)	30	2
Beck Depression Inventory (BDI) (Beck et al., 1961)	14	7
Perceived Stress Scale (PSS-10) (Cohen et al., 1983)	22	18

2. CASE PRESENTATION

A patient in her late twenties – let's call her Johanna – visits a clinical psychologist with prolonged complaints of dizziness on the advice of a specialist. Four months prior to presentation, the patient consulted her general practitioner for several weeks of alternating headache-dizziness symptoms, who referred her to a specialist. The patient's blood count was normal, ophthalmologically and otorhinolaryngologically she was healthy, and a cranial MR scan, to reassure the patient, was also negative. In the otoneurologic outpatient clinic, which specializes in the investigation and treatment of the function of the vestibular system, the consultant doctor diagnosed *benignus paroxysmalis positionalis vertigo* (BPPV).

BPPV is a disorder of the inner ear in which a sudden change of position of the head results in a spasmodic, rotational vertigo lasting less than one minute (Bhattacharyya et al., 2017). The designation "benign" indicates that there is no underlying serious central nervous system disorder, and the prognosis is encouraging. First described in 1921 by Róbert Bárány, the etiology of the disease is controversial. The most widely accepted theories argue that vertigo is related to calcium crystal particles in the ear being dislodged from their normal location and floating in the posterior semicircular canal or adhering to an inappropriate location (Szirmai, 2010). BPPV is the most common vestibular dysfunctions, accounting for the symptoms of about 24% of people seeking medical help for dizziness (Kim et al., 2021). Its lifetime prevalence is 3.6% in women and 1.6% in men (von Brevern et al., 2007), and has a high recurrence rate (50% within 10 years, mostly in the first year, mostly in women; Brandt et al., 2006). Its most common acute symptom, which can be differentially diagnosed, is circular nystagmus, provoked by the so-called Dix-Hallpike maneuver (a special sudden backward tilt of the body and rotation of the head) (Muncie et al., 2017). Although BPPV can heal spontaneously, it usually requires therapy, most commonly so-called particle-repositioning specific exercises such as the Epley or Semont maneuver (Kim et al., 2021).

By the time Johanna came for otoneurologic examination, the characteristic nystagmus was no longer present, but the nature of her complaints suggested the presence of BPPV. (This was subsequently confirmed by a recurrence.) The doctor prescribed balance training (practicing situations that cause discomfort), neck massage and first herbal extracts with sedative effects, followed by selective serotonin reuptake inhibitor (SSRI) type medication (the patient had a bad experience with the drug that directly acted on the dizziness). At the same time, noticing the patient's anxiety and the so-called *chronic subjective dizziness,* which was less organically justifiable, he gave her the clinical psychologist's contact, which the patient, who had always known herself to be "the nervous type", happily accepted.

On the first interview, a slim, tall, well-groomed, extremely polite young woman appeared who was eager to meet expectations. Her main symptom was that she was hampered by dizziness in a number of situations: when getting out of bed, walking up and down stairs, bending down, playing sports, cleaning, and in crowds; she avoided those that were not essential. She also had concentration problems and working in front of a monitor also triggered her symptoms. All these caused frustration and depression and affected her interpersonal relationships.

At the time, Johanna was living a double life between her parents and her fiancé, who lived in a two-generation house with his parents. Her relationship with her future mother-in-law and father-in-law was full of conflict, and she says that she was *'nervous from the moment she stepped into the street'.* She had a university degree and worked in an administrative job as a team leader. Two months before applying for the job, there had been a change of boss and they expected the return of a female colleague she did not like, which made her *'nervous well in advance'.* Within ten months, one family member had fallen seriously ill, and another had died. Her history also revealed a tendency for anxiety and somatization (regular diarrhea before tests). Her psychological-psychiatric history is uneventful. Her mental status is characterized by a changing mood and behavioral signs of anxiety. Diagnostic measures indicated severe impairment in quality of life related to dizziness, moderate anxiety, mild depression and slightly (but not significantly) higher than average perceived stress (see Table 3), which lead to a diagnosis of F4180 *Other specific anxiety disorder* based on clinical picture and test results. Johanna was motivated for psychological support, so we contracted her for ten 50-minute supportive therapy sessions, enriched with cognitive behavioral therapy elements, on a weekly outpatient basis, supported by social security. The therapeutic goal was to reduce anxiety (with the potential for spontaneous resolution of already mild mood symptoms). The patient's diary of her thoughts revealed the most anxiety-provoking situations (e.g. escalator in a mall, standing for an hour while being introduced to the new boss), the negative automatic thoughts that emerged in them *("Dizziness is coming", "It will never go away", "I have a brain tumor")* and the underlying cognitive distortions (fortune telling). The diary also showed that travelling on a weekly basis was stressful, while the home environment and certain activities (such as gardening) were calming, and that this was reflected in symptoms: stronger on more stressful days and weaker on more pleasant days. A six-month pathobiogram showed a parallel between negative life events and the development of symptoms.

Targeted interventions were possible to make at the intervention points highlighted above: restructuring of negative automatic thoughts *("This is a curable disease that can go away with treatment"; "Although I feel dizzy, there is nothing to suggest that there is a malignant process going on in my body"),* metacognitive awareness of cognitive biases *("I tend to think the worst immediately, but it is worthwhile to examine the truth of my thoughts"),* learning relaxation, consciously incorporating pleasant activities into the patient's lifestyle, and finally behavioral trials (deliberate engagement in avoidance situations in ascending order of the anxiety hierarchy). Johanna learned to make her anxiety bearable, her sense of vulnerability to its symptoms decreased, she gradually resumed activities she had previously neglected, the success of which positively reinforced her entrepreneurial spirit. During treatment, a relapse associated with an emotionally stressful event (All Soul's Day), although frightening *("a chasm into which I am falling"),* gave her the opportunity to normalize the relapse and prepare for possible new ones. By the end of the therapy, the patient's deterioration in quality of life related to dizziness had gone from an initial severe to mild, her anxiety and depressive symptoms had become negligible, and her perceived stress level had also decreased (see Table 3).

During the therapy, a doctor-psychologist consultation on the course and prognosis of the disease was carried out on several occasions, initiated from both sides, with the patient's knowledge and consent. Reduction of the SSRI dose was considered safe by the specialist only after a longer period of stability. During two years of follow-up, the patient's dizziness returned significantly on three occasions: once in the context of a follicular tonsillitis, once in the context of a recurrence of BPPV (this time diagnostically verifiable), and once in the context of the death of a close acquaintance. Otherwise, at the time of writing, Johanna's condition is compensated, she has stopped taking psychotropic medication and she is not experiencing anxiety caused by anticipating recurrence.

2. DISCUSSION

Johanna's disease was not diagnosed in primary care, and she reached the appropriate specialist care too late to confirm BPPV with certainty. Sometimes there are delays in the management of patient pathways and the delay in diagnosis increases patient distress. In Johanna's case, the trigger for the hypersensitivity of the vestibular system was BPPV, but the persistence of dizziness was more likely due to the stress of the disease, the lack of knowledge of what caused the symptoms, and the phobic reaction to stimuli provoking dizziness. Avoidance reduced stress in the short term, but in the long term it led to the entrenchment of fears, a reduction in living space and social contacts, and overall, a severe deterioration in quality of life.

A significant percentage of patients suffering from vertigo show symptoms of depression and/or anxiety. This percentage can range from 11-18% (Kim et al., 2016) up to 63.4% (Garcia et al., 2003), depending on the scale cut-offs used. Patients with comorbid dizziness and distress may have symptoms long after their vestibular function has been compensated by objective measures (Yardley, 2000). What's more, BPPV patients with psychiatric symptoms are significantly more likely to relapse within six months than others with only physical symptoms (Wei et al., 2018). In contrast, patients with greater resilience, sense of coherence and life satisfaction are less likely to develop secondary somatoform vertigo (Tschan et al., 2011).

The relationship between vertigo and psychological-psychiatric problems is bidirectional:

a) *Psychological factors may contribute to the development of vertigo.* Anxiety may manifest as a subjective sense of imbalance (in which case no objective abnormality in vestibular function is observed; Szirmai, 2011). Hyperventilation with a psychological background may also lead to dizziness through excessive oxygenation (a diagnostic criterion for panic attacks). Even balance disorders with an organic background and objective symptoms are more common in anxious than non-anxious people. A population-based retrospective cohort study in Taiwan, for example, found that patients with anxiety disorders were more than twice as likely to develop BPPV than healthy individuals (Chen et al., 2016). In an Italian study, those diagnosed with BPPV had significantly more negative life events in the year prior to diagnosis than in matched healthy controls (Monzani et al., 2006), so stress could also turn out to be a trigger. This may also be related to the significant overlap between the anatomical regions and neurotransmitters responsible for the functioning of the vestibular system and emotional states (Balaban et al., 2011).

b) *Dizziness can lead to psychiatric problems.* The loss of balance is frightening for patients, and in the absence of an explanation, they might end up catastrophizing the situation. Patients experiencing balance system disorders often imagine that they are suffering from a terminal illness (Szirmai, 2011). Patients may become avoidant (even to the extent of agoraphobia) of situations that may cause dizziness, and their living space is often reduced, their social contacts are impaired, and their quality of life deteriorates. In the longer term, this can easily lead to depression (Kozak et al., 2018).

It can be deducted from II.) that if the organic disease is treated properly, the psychological symptoms can be alleviated without psychotherapy. Indeed, in a Turkish study of a small group, successful physical treatment of BPPV significantly reduced patients' anxiety levels (Gunes & Yuzbasioglu, 2019). Similarly, in a Chinese study, anxiety, depression, and quality of life scores 3 months after BPPV treatment were significantly better than before treatment (Zhu et al., 2020). However, in the absence of spontaneous remission, patients need to be treated psychologically, because follow-up studies have shown that whether dizziness becomes a long-term disability depends more on psychological than physical factors (Staab, 2006).

In Johanna's case, an improvement in psychological indicators and an increase in the patient's level of everyday functioning were confirmed. The therapy did not aim at exploring the genetic and life-history background of the disposition for anxiety, at modifying the patient's interpersonal functioning (e.g. the need to conform), at deepening the understanding of the causes of stress in the work environment and at resolving them. In a somatic setting, long *trait-change* therapies are rarely possible, and instead short, problem-oriented, symptom-reducing and *state-change* support takes place. Yet, when psychological problems are associated with physical illness, improving quality of life and restoring health is a moral obligation. In Hungary, too, the stigma surrounding psychological aspects is decreasing slowly but encouragingly, and more and more doctors and patients are open to psychological help – which is, of course, not always necessary. This also requires the psychologist to demonstrate the legitimacy of his work in a demystified way that is easy for both doctor and patient to follow, if possible, using proven effective methods. This complex approach is the closest we can come to the renaissance of the holistic approach and to curing the person and not the disease.

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The chapters in this volume provide a comprehensive overview of the clinical applications of health psychology, a relatively new but rapidly developing field. They provide an insight into the practice and challenges of psychological care and introduce the theoretical background based on research evidence. Most of the chapters are organized around case studies, providing a rich synthesis of the work of health psychologists practicing in different areas of care. The authors and editors of the volume are current trainees, and the faculty of the Applied Health Psychology postgraduate program at the University of Szeged, Hungary. The volume can serve as source material and a practical guide for psychologists, physicians, and other health professionals, both in healthcare work and training. More generally, it can guide those interested in navigating through the field and the work of health psychologists in promoting effective healing and health promotion.

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