Anett Sánta, Lilla Lucza, Beatrix Rafael

Internal Medicine – A Case Report in Gastroenterology

DOI: 10.14232/sztep.chpp.2022.2

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 Question-

naire (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. Through-

out 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, extraintestinal symptoms), previous surgeries and hospital admissions may predispose pa-

tients 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.

References

Altorjay, I. (2014). Az emésztőszervek betegségei [Illnesses of the Digestive Tract]. In R. Ádány, I. Kárpáti, Gy. Paragh (szerk.), *Népegészségügyi medicina [Public Health Medicine]* (155–187. o.). Medicina Könyvkiadó Zrt.

Ananthakrishnan, A. N., Khalili, H., Konijeti, G. G., Higuchi, L. M., De Silva, P., Korzenik, J. R., Fuchs, C. S., Willett, W. C., Richter, J. M., Chan, A. T. (2013). A prospective study of long-term intake of dietary fiber and risk of Crohn's disease and ulcerative colitis. *Gastroenterology, 145*(5), 970–977.

Bannaga, A. S., Selinger, C. P. (2015). Inflammatory bowel disease and anxiety: links, risks, and challenges faced. *Clinical and experimental gastroenterology, 8,* 111–117.

Bernstein, C. N., Hitchon, C. A., Walld, R., Bolton, J. M., Sareen, J., Walker, J. R., Graff, L. A., Patten, S. B., Singer, A., Lix, L. M., El-Gabalawy, R., Katz, A., Fisk, J. D., Marrie, R. A. (2019). Increased burden of psychiatric disorders in inflammatory bowel disease. *Inflammatory bowel diseases, 25*(2), 360–368.

Bhamre, R., Sawrav, S., Adarkar, S., Sakaria, R., Bhatia, S. J. (2018). Psychiatric comorbidities in patients with inflammatory bowel disease. *Indian Journal of Gastroenterology, 37*(4), 307– 312.

Bonaz, B. L., Bernstein, C. N. (2013). Brain-gut interactions in inflammatory bowel disease. *Gastroenterology, 144*(1), 36–49.

Byrne, G., Rosenfeld, G., Leung, Y., Qian, H., Raudzus, J., Nunez, C., Bressler, B. (2017). Prevalence of anxiety and depression in patients with inflammatory bowel disease. *Canadian Journal of Gastroenterology and Hepatology, 2017,* 6496727.

DeJong, H., Hillcoat, J., Perkins, S., Grover, M., Schmidt, U. (2012). Illness perception in bulimia nervosa. *Journal of health psychology, 17*(3), 399–408.

Devins, G. M., Edworthy, S. M., Seland, T. P., Klein, G. M., Paul, L. C., Mandin, H. (1993). Differences in illness intrusiveness across rheumatoid arthritis, end-stage renal disease, and multiple sclerosis. *Journal of Nervous and Mental Disease, 181*(6), 377–381.

Dudley-Brown, S. (2002). Prevention of psychological distress in persons with inflammatory bowel disease. *Issues in Mental Health Nursing, 23*(4), 403–422.

Gracie, D. J., Guthrie, E. A., Hamlin, P. J., Ford, A. C. (2018). Bi-directionality of brain–gut interactions in patients with inflammatory bowel disease. *Gastroenterology, 154*(6), 1635– 1646.

Graff, L. A., Walker, J. R., Bernstein, C. N. (2009). Depression and anxiety in inflammatory bowel disease: a review of comorbidity and management. *Inflammatory bowel diseases, 15*(7), 1105–1118.

Iglesias-Rey, M., Barreiro-de Acosta, M., Caamaño-Isorna, F., Rodríguez, I. V., Ferreiro, R., Lindkvist, B., González, A. L., Dominguez-Munoz, J. E. (2014). Psychological factors are associated with changes in the health-related quality of life in inflammatory bowel disease. *Inflammatory bowel diseases, 20*(1), 92–102.

Irvine, E. J., Zhou, Q., Thompson, A. K. (1996). The Short Inflammatory Bowel Disease Questionnaire: A Quality of Life Instrument for Community Physicians Managing Inflammatory Bowel Disease. *American Journal of Gastroenterology, 91*(8) 1571–1578.

Katon, W., Lin, E. H., Kroenke, K. (2007). The association of depression and anxiety with medical symptom burden in patients with chronic medical illness. *General hospital psychiatry, 29*(2), 147–155.

Keefer, L., Kane, S. V. (2017). Considering the bidirectional pathways between depression and IBD: recommendations for comprehensive IBD care. *Gastroenterology & hepatology, 13*(3), 164.

Knowles, S. R., Graff, L. A., Wilding, H., Hewitt, C., Keefer, L., Mikocka-Walus, A. (2018). Quality of life in inflammatory bowel disease: a systematic review and meta-analyses–part I. *Inflammatory bowel diseases, 24*(4), 742–751.

Kovács, Á., Lakatos, L. (2018). *Gyulladásos bélbetegségek: amit az IBD-ről tudni kell [Inflammatory Bowel Diseases: What You Should Know about IBD].* Medicina Könyvkiadó Zrt.

Kroenke, K., Spitzer, R. L. (2002). The PHQ–9: a new depression diagnostic and severity measure. *Psychiatric annals, 32*(9), 509–515.

Kroenke, K., Spitzer, R. L., Williams, J. B. (2001). The PHQ 9: validity of a brief depression severity measure. *Journal of general internal medicine, 16*(9), 606–613.

Lewis, K., Marrie, R. A., Bernstein, C. N., Graff, L. A., Patten, S. B., Sareen, J., Fisk, J. D., Bolton, J. M. (2019). The prevalence and risk factors of undiagnosed depression and anxiety disorders among patients with inflammatory bowel disease. *Inflammatory bowel diseases, 25*(10), 1674–1680.

Long, M. D., Hutfless, S., Kappelman, M. D., Khalili, H., Kaplan, G. G., Bernstein, C. N., Colombel, J. F., Herrinton, L., Velayos, F., Loftus Jr, E. V., Nguyen, G. C., Anantha-krishnan, A. N., Sonnenberg, A., Chan, A., Sandler, R. S., Atreja, A., Shah, S. A., Rothman, K., Leleiko, N. S., Bright, R., ... Sands, B. E. (2014). Challenges in designing a national surveillance program for inflammatory bowel disease in the United States. *Inflammatory bowel diseases, 20*(2), 398–415.

Maity, S., Thomas, A. G. (2007). Quality of life in paediatric gastrointestinal and liver disease: a systematic review. *Journal of pediatric gastroenterology and nutrition, 44*(5), 540–554.

Martínez-Martínez, M. I., Alegre-Martínez, A., García-Ibánez, J., Cauli, O. (2019). Quality of life in people with coeliac disease: psychological and socio-economic aspects. *Endocrine, Metabolic & Immune Disorders-Drug Targets (Formerly Current Drug Targets-Immune, Endocrine & Metabolic Disorders), 19*(2), 116–120.

McCombie, A. M., Mulder, R. T., Gearry, R. B. (2013). How IBD patients cope with IBD: a systematic review. *Journal of Crohn's and Colitis, 7*(2), 89–106.

Miheller, P., Nagy, F., Lakatos, L., Molnár, T., Bene, L., Lakatos, P. L., Újszászy, L., Hunyady, B., Banai, J. (2009). A felnőttkori gyulladásos bélbetegségek anti-TNF-alfa kezeléséről [Regarding the Anti-TNF-Alpha Therapy of Inflammatory Bowel Diseases in Adulthood]. *LEGE ARTIS MEDICINAE, 19*(8–9), 515–522.

Nagy, F. (2010). Gyulladásos bélbetegségek [Inflammatory Bowel Diseases]. In Zs. Tulassay (szerk.), *A belgyógyászat alapjai 1 [Basics of Internal Medicine].* Medicina Könyvkiadó Zrt.

Navabi, S., Gorrepati, V. S., Yadav, S., Chintanaboina, J., Maher, S., Demuth, P., Stern, B. Stuart, A., Tinsley, A., Clarke, K., Williams, E. D., Coates, M. D. (2018). Influences and impact of anxiety and depression in the setting of inflammatory bowel disease. *Inflammatory bowel diseases, 24*(11), 2303–2308.

Neuendorf, R., Harding, A., Stello, N., Hanes, D., Wahbeh, H. (2016). Depression and anxiety in patients with inflammatory bowel disease: a systematic review. *Journal of psychosomatic research, 87,* 70–80.

Novak, M., Mah, K., Molnar, M. Z., Ambrus, C., Csepanyi, G., Kovacs, A., Vamos, E., Zambo, M., Zoller, R., Mucsi, I., Devins, G. M. (2005). Factor structure and reliability of the Hungarian version of the Illness Intrusiveness Scale: invariance across North American and Hungarian dialysis patients. *Journal of psychosomatic research, 58*(1), 103–110.

Nowakowski, J., Chrobak, A. A., Dudek, D. (2016). Psychiatric illnesses in inflammatory bowel diseases-psychiatric comorbidity and biological underpinnings. *Psychiatria Polska, 50*(6), 1157–1166.

Rochelle, T. L., Fidler, H. (2013). The importance of illness perceptions, quality of life and psychological status in patients with ulcerative colitis and Crohn's disease. *Journal of health psychology, 18*(7), 972–983.

Rosselli, M., Salimbeni, M. V., Bessi, C., Nesi, E., Caruso, S., Arboretti, D., Migliorini, E., Caterino, E., Parentini, E., Generini, S., Zipoli, M., Romanelli, R. G., Rosselli, M., Marra, F., Laffi, G., Stasi, C. (2015). Screening of distress among hospitalized patients in a department of internal medicine. *Asian journal of psychiatry, 18,* 91–96.

Sipos, K., Sipos, M. (1983). The Development and Validation of the Hungarian Form of the State-Trait Anxiety Inventory. In C. D. Spielberger, R. Diaz-Guerrero (szerk.), *Cross-cultural anxiety, Volume 2.* (27–39. o.). Hemisphere.

Spielberger, C. D., Gorsuch, R L., Lushene, R. E. (1970). *Manual for the State-Trait Anxiety Inventory.* Consulting Psychologists Press.

Stapersma, L., van den Brink, G., Szigethy, E. M., Escher, J. C., Utens, E. M. (2018). Systematic review with meta analysis: anxiety and depression in children and adolescents with inflammatory bowel disease. *Alimentary pharmacology & therapeutics, 48*(5), 496–506.

Újszászy, L., Horváth, G. (2011). Életminőség vizsgálatok és az IBD [Quality of Life Researches and IBD]. In Á. Kovács, L. Lakatos (szerk.), *Gyulladásos bélbetegségek [Inflammatory Bowel Diseases]* (409–415. o.). Medicina Könyvkiadó Zrt.

Van Oudenhove, L., Levy, R. L., Crowell, M. D., Drossman, D. A., Halpert, A. D., Keefer, L., Lackner, J. M., Murphy, T. B., Naliboff, B. D. (2016). Biopsychosocial aspects of functional gastrointestinal disorders: how central and environmental processes contribute to the development and expression of functional gastrointestinal disorders. *Gastroenterology, 150*(6), 1355–1367.

Zhang, C., Byrne, G., Lee, T., Singer, J., Giustini, D., Bressler, B. (2018). Incidence of suicide in inflammatory bowel disease: a systematic review and meta-analysis. *Journal of the Canadian Association of Gastroenterology, 1*(3), 107–114.