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| Aim                 Introduction                                                                                                                       Task  List the most frequent illness related stress factors!                                                                                                                                            Task:  Apply the three-column method to one of your experiences of illness!                                                                                                Summary                     Reading                                                                                                                                                                                   Reading                                                        Important                     Example                                                                                                                       Reading                                                                                                                                                 Reading                                                                                                                                                                             Reading                                                                                                      Reading                         Task  List the interventions that improve cooperation!                                                                                                                  Task  List the reasons for the termination of medical treatment!                                                 Reading                                                                                              Task  List the reasons for terminating clinical treatment.                                         Task  List the psychotherapeutic means for avoiding the termination of clinical treatment.                                                                       Reading | ***Chapter I./2.: Psychological Responses to Illness and their Psychotherapeutic Treatment***  **The basic psychotherapeutic task for a doctor** is to understand how the patient experiences their illness subjectively. If the illness causes psychological problems, the doctor is to ease it with adequate psychotherapeutic interventions.  **Adequate** psychotherapeutic interventions influence the emotional and behavioural responses to the illness, reduce stress and improve the course of the illness.  **Introduction**  We can observe huge differences between the way patients experience their illness both in outpatient and in inpatient treatment. Some can react to an incurable, terminal illness with great wisdom, self-control and humour. Others react to a quick, mild and completely curable disease with terror, despair or fury.  The doctor has to pay attention to the patient’s psychological response to the illness. In case the psychological response to the illness has a negative influence on the patient, on the cooperation with the treatment and on the patient’s social activity, the doctor has to use psychotherapeutic tools to help them.    **Case study**  XY is an N years old female health care worker, who spotted nodes in her right breast. It occurred to her that it was cancer, which horrified her. She thought, if it was cancer, it meant the removal of her breast, which she would not be able to bear. This fear stopped her from asking for help. Due to psychological problems, she was admitted to in-hospital psychotherapic treatment, where she mentioned the nodes to her doctor. During her examination, a malignant tumour was discovered, removal by operation and a following citostatic treatment was recommended. During the process, the patient became uncertain several times about taking part in the treatment. She had suicidal thoughts and she had the idea that she would have left her life up to the natural course of her unattended illness by avoiding treatment.  It should be highlighted in her anamnesis, that she was particularly endangered in terms of social support. Following her birth she was taken to a children’s home, she did not know her parents. She was housed with foster parents who repeatedly and seriously beat her in her childhood. Having had a child, she fell into post partum depression and obsessive-compulsive disorder. Her husband left her, and then sued her for occasional access to see his daughter in educational centres, with child protection specialists being present. Her husband’s way of upbringing made the daughter turn against the patient. Apart from a few female friends and her psychotherapists, she had little support.  Due to the recurring depressive phase, her unstable mood and earlier suicidal thoughts and attempts, she needed extra attention.  The risk of maladaptive response to illness was high in her case.  **I./2.1. Stress Caused by Illness**  The factors influencing behavioural and emotional responses to stress caused by illness are: the patient’s personality, their cognitive schemes, coping strategies and defensive mechanisms. Lazarus’s modified model is presented in figure 1.  [P\_1\_abra\_I\_2\_1\_fejezet.JPG]  Aláírás: Figure 1.  The individual’s illness is in the top six most serious stress factors in various international surveys (Groves and Muskin, 2005). Below we summarise the illness related factors causing stress for most people, however, the amount of stress and the reaction to stress depends on the patients’ personality.   1. Illness 2. Merely being in a health care institute, which itself may be frightening and may evoke painful sad memories. 3. The isolating effect of hospitals: In hospital, one is detached from their usual surroundings, social supports. 4. In case of non-outpatient patients, the obligatory hospital clothes are accompanied by the loss of feeling individual, and the loss of control and privacy (Gazzola and Muskin 2003). 5. The opening up of the body (injection, infusion, drawing of blood, operation, various other invasive examining methods), entering into the body through its natural openings, staying long in confined places or machines are grave stress factors. 6. Nudity, revelation of the intimate parts of the body, contact with these parts during examination, discussing intimate topics alone creates stress and causes shame in many cases. 7. Facing the possibility of one’s own death. 8. Inescapable contact with strangers, the need to share a room with other sick people, or dying people, witnessing a roommate’s death. 9. Dependence on hospital staff with basic tasks: eating, keeping clean, doing one’s toilet. 10. Lowering of self-esteem. 11. Pain 12. Lack of sleep, problems with sleep 13. Restriction of the ability to move, difficulties arising from the functional disorder of sense organs 14. Dropping out of work, inability to involve in useful activities, loss of feeling of being useful, of being productive.     **Reading:**  GROVES, M. S. and MUSKIN, P. R: Psychological Responses to illness. In: Levenson J. L, Editor. Textbook of Psychosomatic Medicine. Washington DC: American Psychiatric Publishing, 2005: 67-88.  GAZZOLA, L, and MUSKIN, P. R: The Impact of Stress and the Objectives of Psychosocial Interventions, in Schein, L. A. Bernard, H. S, Spitz, H. I, Muskin, P. R, Editors. Psychosocial Treatment for Medical Conditions: Principles and Techniques. New York: Brunner-Routledge, 2003: 373–406.  **I./2.2. Stress Caused by Illness with Different Personalities**  The patient’s personality style or disorder defines how they experience the illness, the interventions accompanying the treatment, and the social circumstances. Each different personality requires a different communication style from the doctor. Identifying the patient’s personality type plays an important role in choosing the appropriate intervention. For instance, when we inform patients about the treatment, a compulsive type of person requires detailed and accurate information, whereas a hystrionic patient is less interested in details.  The various personality types’ unique reactions to stress caused by illness are presented in detail in unit 12. (12**. Psychotherapeutic treatment of problem patients. Personality disorders.)**  **I./2.3. Illness and Cognitive Schemes**  According to cognitive psychotherapy, it is the evaluation of the illness that defines what type of emotional and behavioural response is triggered from the patient.  When assessing disorders caused by illness, in cognitive therapy we apply the *event →evaluation→*reaction scheme. It is easiest to identify the symptom-related cognitions using the three-column technique. The main point of cognitive theory is that the evaluation of the event defines the type of reaction triggered by an event. When applying the three-column technique, we ask the patient to recall a situation evoking negative emotions and to observe how they evaluated the situation: what emotions, kinaesthetic perceptions were triggered and how they had behaved, or what thoughts occur to them about the event and the reactions now, in retrospect.  [P\_1\_melleklet\_I\_2\_3\_fejezet]  Felirat: Appendix 1  For example, the medical report diagnosing a node in the patient’s breast may be an event that the patient may evaluate as ‘I have got a terminal illness, there is no way to help me’. This catastrophizing evaluation may trigger the following reactions: fear of death, hopelessness, avoidance of further medical aid.  [P\_2\_melleklet\_I\_2\_3\_fejezet]  Felirat: Appendix 2  However, if her evaluation is that it is worth continuing examinations, perhaps it is not a malignant illness, or a lot of women have long survived malignant breast tumour due to efficient treatment, then the following reaction may be triggered: hope, continuation of examinations, cooperation with medical treatments.  [P\_3\_melleklet\_I\_2\_3\_fejezet]  Felirat: Appendix 3  **The aim of the technique** is for patients to record events, negative feelings and evaluations in a three-column diary.Discussing these might modifythe negative evaluations towards a more balanced and realistic evaluation, which might result in a change of reactions as well. The technique for revaluating an event is called the five-column method. An example of the five-column method can be found in appendix 4.  [P\_4\_melleklet\_I\_2\_3\_fejezet]  Felirat: Appendix 4  **As a summary**, it can be said that often extremely negative meanings assigned to illnesses form the background to illness related fears. It is worth identifying, querying or modifying patients’ cognitive evaluations.  **Method:** Cognitive conceptualisation of the stress caused by illness. Three-column, then five-column worksheets.  **Reading**  GROVES, M.S, MUSKIN, P. R: Psychological responses to illness. In: Levenson, J. L, Editor. Textbook of Psychosomatic Medicine. Washington DC: American Psychiatric Publishing, 2005: 67-88.  **1./2.4. The Meanings and the Model of Illness**  Personality, cultural background, circumstances in life define what meaning the individual assigns to the illness and what explanatory model they have in mind about the nature of the illness. Lipowski distinguished eight conceptualisations of illnesses:   1. The illness as a challenge. 2. The illness as an enemy. 3. The illness as a punishment. 4. The illness as a weakness. 5. The illness as relief. 6. The illness as a strategy. 7. The illness as an irretrievable loss and damage. 8. The illness as value (Lipowski 1970).     Practitioners form their images of illnesses based on scientific knowledge acquired during their studies. However, the topic of illness is of such great importance in people’s life that non-professionals also form some conceptions about the nature of illnesses. These are called ‘naive illness theories’. These naive theories are made up partly from traditional popular ideas, schoolbook knowledge, scientific educational ideas, religious-cultural views, knowledge of alternative medicine and knowledge passed on from doctors’ educational activities.  **The main topics of naive models of illnesses:**   1. The name and symptoms of the illness. 2. The cause of the illness, its explanatory model, ideas about why the illness has developed. 3. The course of the illness in time, e.g.: acute, chronic, and periodic. 4. The consequences of the illness: e.g., what influence it will have on them. 5. The treatment or control of the illness: how they think they can recover from the illness (Leventhal et. al., 1992).     Revealing the patient’s own model of illness is an indispensable part of the examination. Figure 2. summarises the questions related to each element of the model of illness.  [P\_2\_abra\_I\_2\_4\_fejezet]  Felirat: Figure 2.  Sometimes a mismatch between a patient’s own model of the illness and the treatment offered by the doctor is responsible for co-operational problems. For instance, a part of the people under the influence of alternative medicine consider interventions involving drugs harmful, unless the active substance is made from herbs, consequently they will not take the pills recommended by the practitioner.  A common fallacy about tumours is that they are incurable. There are kinds of tumour that if recognized at an early phase, can be cured very effectively.  If the doctor considers the patient’s naive model of the illness a hindrance to the efficient treatment, then educational, informative, and in some cases psychotherapeutic, intervention has to be initiated to form a model of the illness more suitable for the treatment. This activity involves mere informing in some cases, whereas it may involve serious psychotherapeutic interventions in others.  The therapeutic alliance is a major part of the therapeutic interventions. One of the elements of the therapeutic alliance is the consensus about the goal of the treatment and the tasks necessary for reaching this goal. The goals and methods of the treatment depend on the type of model we have about the illness. The models of the practitioner and the patient have to match so that the patient can consider taking part in the treatment sensible.  For example, a patient suffering from erectile dysfunction thinks it is his sinful sexual fantasies about his female colleague that have created his impotence, therefore no urological examination can be helpful as the only aid to the problem is penitence. Figure 3. presents the interview method for revealing the model about the illness.  [P\_3\_abra\_I\_2\_4\_fejezet]  Felirat: Figure 3.  **Reading:**  GROVES, M. S. and MUSKIN, P. R: Psychological responses to illness. In: Levenson J. L., Editor. Textbook of Psychosomatic Medicine. Washington DC: American Psychiatric Publishing, 2005: 67-88.  LEVENTHAL, H. DIEFENBACH, M. and LEVENTHAL, E. A: Illness cognition: Using Common Sense to Understand Treatment Adherence and Affect Cognition Interactions. Cognitive Therapy and Research 1992; 16:143–163.  LIPOWSKI, Z. J: Physical Illness, the Individual and the Coping Process. Psychiatry Medicine 1970; 1:91–102.  **I./2.5.: Coping Strategies: conscious, behavioural forms of coping with stress caused by illness**  Research shows that patients use several coping strategies to cope with stress caused by illness. There are various strategies.  ***Lazarus***(1999) groups coping strategies into two classes:  − ***problem-centred coping*:** the person focuses on the situation and the problem, attempting to change them so as to be able to avoid them in the future.  − **emotion-centred coping:** the person focuses on easing the emotional responses caused by stress, on stopping negative emotions from overflowing.  The choice of coping strategies is also influenced by what the patient thinks about their illness. If their evaluation says they cannot do anything, then they will use emotion-centred coping. In case they evaluate their illness as changeable and controllable, they will rather use a problem-centred strategy (Folkman et al, 1993, Schusler 1993). Doctors’ psychotherapeutic intervention in this case may take the form of surveying how the patient evaluates their own situation and what coping they choose. Then, helping to modify the evaluation, the doctor could guide the patient towards alternative evaluation and more adaptive coping.  **Example:**  Having been diagnosed with diabetes mellitus Attila had thought he could not control his blood sugar level and had applied mainly emotion-centred coping, e.g. avoidance and denial. After his practitioner acquaintance changed his evaluation of the situation by properly informing him about how Attila can influence his own blood sugar level, he switched from the emotion-centred to the problem-centred coping strategy: he changed his diet and took up regular exercises.  **Lazarus distinguished 8 types of coping strategies:**   1. Confrontative coping (hostile or aggressive effort to change the situation). 2. Detachment (attempt to detach from the situation mentally). 3. Self-control (regulation of own emotions and actions). 4. Looking for social support (asking for emotional support or information from others). 5. Acceptance of responsibility (acceptance of the individual’s role in the problem). 6. Using escape and avoidance (cognitive or behavioural avoidance of the problem, escape from the situation). 7. Planned problem solving (intentional and carefully planned effort to solve the problem). 8. Positive revaluation of the situation (the situation is put into a new, more positive framework) (Folkman et al. 1986).     The frequent use of certain coping strategies may be characteristic of a person, like a **character trait**. Optimally, a flexible personality adapts to the situation and changes their choice of coping strategy moment by moment.  It is worth revealing from the life history how a person reacted to serious stress or illness, as it might happen that the patient acts similarly even if the earlier coping strategy was not effective enough. It has also been observed that at different phases of the illness, the same people apply different coping strategies. For example, having been diagnosed with breast cancer, a woman initially opted for social coping (met and talked with friends and relatives), whereas later on in the treatment they tended to choose problem-solving coping (carefully followed the medication instructions of citostatic treatment).   The **meaning of the illness** also determines the choice of the coping strategy. In Schusler’s research (1992) the meaning assigned to the illness determined how subjects of the examination chose their coping strategies. Adaptive, planned, problem-oriented strategies were used by those considering the illness as a challenge, whereas those considering it their enemy, punishment or relief, used less adaptive coping strategies and had more numerous psychological symptoms.  **Reading**  ROVES, M. S. and MUSKIN, P. R: Psychological responses to illness. In: Levenson J. L., Editor. Textbook of Psychosomatic Medicine. Washington DC: American Psychiatric Publishing, 2005: 67-88.  FOLKMAN, S. LAZARUS, R. DUNKEL-SCHETTER, C. and MTSAI: The Dynamics of a Stressful Encounter: Cognitive Appraisal, Coping and Encounter Outcomes. Journal of Personality and Social Psychology 1986; 50:992–1003.  LAZARUS, R. S.: Stress and Emotion: A New Synthesis. New York: Springer, 1999.  SCHUSSLER, G.: Coping Strategies and Individual Meanings of Illness. Social Science and Medicine 1992; 34:427–432.  **I./2. 6. Defence Mechanisms: the unconscious forms of coping with stress caused by illness**  The concept and types of defence mechanism were first systematically explained by Anna Freud (Freud, 1996). This chapter does not aim at presenting the history of the concept or its various interpretations. The aim of this chapter is to introduce the basic concept of defence mechanism and to give a detailed description of the defence mechanism called denial.  **The characteristics of defence mechanisms (Vaillant 1993):**   1. The person is not conscious of the defence. The mind deludes them to decrease conflict and suffering. 2. It is the nature of defence to distort the inner or outer reality. The amount and content of the distortion depends on the type of the defence, certain defences hinder the integration of instincts and desires into consciousness, and others distort the outer reality and social relationships.      1. The consequences of the defences may seem strange for outer observers; however, the subject involved takes no notice of their presence. It is up to the doctor’s decision whether he directs the patient’s attention to the process distorting reality or not.      1. Defences are creative. The new perception created by the mind differs from reality.      1. There is psychological conflict in the background of the defence. The point of the conflict is that the goals of the motivational systems in the organism, the culturally acquired norms and reality cannot be harmonized; there is a conflict between these. By means of the defence, some of these enter the conscious mind, some do not.      1. Defences are adaptive and not necessarily pathological. Certain defences are more adaptive. Defences are the involuntary workings of the mind.     **Denial** is one of the most frequent illness-related defences. In case of denial, either some experiences related to the illness remain in the unconscious of the patient or they deny them.  **Typical forms of denial:**   1. The diagnose is rejected. 2. The consequences of the symptoms are not accepted, or the seriousness of the situation is minimized. 3. Treatment is avoided. 4. Shows no emotional reaction to the news of the illness.     **Reading**  Freud, A. (1966). *The Ego and the Mechanisms of Defence*, London: Hogarth Press and Institute of Psycho-Analysis.  GROVES, M. S. and MUSKIN, P. R.: Psychological responses to illness. In: Levenson J. L., Editor. Textbook of Psychosomatic Medicine. Washington DC: American Psychiatric Publishing, 2005: 67-88.  VAILLANT, G. E.: The Wisdom of the Ego. Cambridge, MA: Harvard University Press, 1993.  **I./ 2. 7. Emotional Response to Illness**    The meaning of the illness and the patient’s personality and evaluation influence which emotions the illness, the examination or the treatment process triggers.  The emotions most frequently triggered by the stress caused by illness may influence the cooperation of the patient. Identifying the patient’s emotions helps doctors form a proper therapeutic relationship.    The fact of the illness, its symptoms, the examinations and interventions may cause fear, joy, anger, sadness, disgust, shame, remorse, envy and other emotions, as well. Recognition of the emotional state and the ability to help the patient handle their emotions may improve practitioners’ jobs largely.  **I./2.8. Behavioural Responses to Stress Caused by Illness**  The patients’ responses to stress caused by illness may be either adaptive or maladaptive. The practitioner can plan a psychotherapeutic intervention that guides the patient’s maladaptive behavioural reactions in the right direction by paying attention to the patient’s personality, cognitive schemes, mistakes in logic, coping strategies, emotional responses. This chapter summarises patients’ typical adaptive and maladaptive behavioural responses.  ***I./2.8.1.  Adaptive Responses***   1. **Looking for social support**. Patients who function well in social life can get and ask for emotional and material help from friends and family when they fall ill and are admitted to hospital. Certain patients have problems with social dependence and find it difficult to ask for help. A psychotherapeutic intervention may help such patients to overcome the defences that block the request for help. Supportive peer groups consisting of patients suffering from similar illnesses may also have an important role in coping with illnesses. Patients with identical clinical pictures can learn from each other, share experiences, and feel less estranged from other people because of their illness. Practitioners dealing with special patient groups play the important role of creators of help groups for patients with identical clinical pictures.      1. **Altruism**. Patients suffering from serious, chronic illnesses often start helping fellow patients, create self-help organizations, donate to different funds, take part in research with the awareness that they may be of help to the patients of the future. Such forms of altruism help to improve patients’ self-evaluation, feeling of being useful, which were decreased by their illness.      1. **Revaluation of one’s set of values**. In certain cases, the illness helps to revaluate what is important in life.      1. **Becoming an expert of one’s own illness.** With certain patients**,** the thorough study of the causes of the state threatening them, the possibilities of treatment, the advantages and disadvantages and side effects of different treatment methods largely decreases the stress and increases the feeling of competence. Other patients do not like dealing with such questions, as it only increases their anxiety.     **Reading:**  GROVES, M. S and MUSKIN, P. R.: Psychological Responses to Illness. In: Levenson, J. L. Editor. Textbook of Psychosomatic Medicine. Washington DC: American Psychiatric Publishing, 2005: 67-88.   ***I./2.8.2.  Maladaptive Behavioural Responses****:*  Non-adherence to the treatment plan. 50% of the patients do not follow the medication instructions of treatments and do not take the pills. (Groves and Muskin, 2005).  It is important to define the amount and extent of non-adherence: does it apply only to certain pills, or to the lifestyle principles, or to cooperation with a certain practitioner, or is it a general problem? Identifying the context helps in revealing underlying motives of co operational problems.  From a subjective point of view, the patient has his good reasons for not cooperating. Revealing this subjective point of view could be the starting point of a hand in hand outlining of the co operational strategy. **One of the most frequent tasks of practitioners’ everyday psychotherapeutic activity is to overcome the psychological obstacles to compliance.**  ***I./2.8.3.*** Reasons of Non-Compliance in Treatment   Apart from psychological ones, other causes may lead to the lack of compliance. For example, the patient:   * cannot afford the treatment, * suffers from side effects, * cannot attend treatment because of their children or work, * cannot reach the premises of the treatment due to difficulties with getting there by public transport     Lack of information, the patience’s lack of knowledge may also block cooperation. The education of knowledge about the illness in a form and at a level that matches the patient’s level of education and intellectual capacities, are important means of improving cooperation. It is worth asking the patient to retell what they understood from the orientation. If understanding is limited, it is worth involving relatives in the treatment.  If the patient’s beliefs about health, their explanatory models of the illness differ from the medical paradigm, these may obstruct cooperation. It is worth revealing the patient’s cultural, religious, scientific views on health and their explanatory models about the illness. Accepting the patient’s views and conciliating them, it is worth outlining a mutually acceptable explanatory model of the illness, and placing the interventions into that model.  **Reading**    GROVES, M. S and MUSKIN, P. R.: Psychological responses to illness. In: Levenson, J. L., Editor. Textbook of Psychosomatic Medicine. Washington DC: American Psychiatric Publishing, 2005: 67-88.   ***I./2.8.4.*** Mental Disorder related Non-Compliance  Resistance to the self-esteem spoiling effects of the illness. Several people assign a meaning to the illness, which worsen their self-esteem, so they would rather avoid the treatment as it also reminds them of the fact that they are ill. Patients having difficulties enduring helplessness, dependence, defencelessness do not cooperate because in their experience medical treatment threatens their independence and lowers their self-esteem.  The feeling of anger triggered by the medical staff, the illness, or the diagnosis may also hinder compliance. The anger may be reasonable, then it is worth admitting our mistake. However, it may happen that the patient has a false evaluation of the situation, or they are inclined to feel unreasonable anger on account of their personality.  **Denial**: Denial of the illness itself, or the seriousness of the illness also hinders adequate cooperation.  One of the most important prerequisites for adequate compliance is the feeling of **trust** towards the doctor. Patients displaying psychotic, paranoid symptoms or those with serious personality disorder find it hard to form a trustful relationship with their physician. In such cases, the formation of an adequate trustful relationship requires extra effort on the physician’s side.  Comorbid psychiatric illnesses may also hinder compliance.  - Due to their feeling of omnipotence and their lifestyle’s disorder, maniac patients do not cooperate.  - In case of depression, motivation is low, or due to a kind of death wish, the patient does not cooperate.  - Cooperation may be hindered by fear of the treatment, drugs’ side effects or phobias about the different interventions (drawing of blood, injection, and dental) in case of anxiety disorders.  - Any drug and alcohol use causes motivational and cognitive disorders  - In cases of disorders due to the decline of mental capacities, patients cannot remember or follow the treatment plan.  **I./2.9.  Interventions Improving Compliance**  **1. Assessment of the compliance.** During assessment,judgemental phrases are to be avoided. The use of **normalizing expressions** instead of moralizing, that is, a phrasing mode that presents the behaviour as frequent improves honesty.   Take, for example, the following normalizing phrasing: ‘*Many patients find it hard to take their pills regularly. Do you have problems with it?’* which is better than the moralizing alternative, ‘You take your pills regularly, don’t you?’  2. Make sure the patient is supplied with ample information about the illness and its treatment.  3. Elimination of cognitive disorders.  4. The revelation of the psychological motives hindering cooperation and their psychotherapeutic treatment.  5. Treatment and diagnosis of comorbid psychiatric illnesses.  6. The revelation and possible treatment of the treatment-related factors that hinder cooperation: side effects of medicines, costs, and complexity of treatment.  7. Identification, acceptance of cultural beliefs that hinder compliance and joined search for solution.  8. Avoidance of blaming, threatening, humiliating the patient. Threatening statements like ‘If you don’t take tablets, you’ll die of heart attack’ usually have bad influence on the relationship and the later cooperation.    9. The motivational use of positive affirmations is usually more effective than negative affirmations.  For example, ‘If you take tablets, you’ll have better chances avoiding serious heart problems.’  10. Involving members of the family in the treatment.  11. Pay attention to doctor patient relationship and form an efficient therapeutic alliance. (Becker and Maiman 1980; Chen 1991)  **Reading:**  BECKER, M. H. and MAIMAN, L. A: Strategies for Enhancing Patient Compliance. Journal of Community Health 1980; 6:113–135.  CHEN, A: Non-Compliance in Community Psychiatry: A Review of Clinical Interventions. Hospital and Community Psychiatry 1991; 42:282–286.  GROVES, M. S. and MUSKIN, P. R.: Psychological Responses to illness. In: Levenson, J. L. Editor. Textbook of Psychosomatic Medicine. Washington DC: American Psychiatric Publishing, 2005: 67-88.  **I./2.10.  Termination of the Treatment, Untimely Abandonment of the Hospital**  One of the most important tasks requiring psychotherapeutic intervention is checking out of hospital attendance despite the doctor’s advice, and the intention to terminate treatment despite the doctor’s advice.  ***I./2.10.1. The most frequent causes of terminating clinical treatment despite the doctor’s advice:***  1. Anger with staff or dissatisfaction with the treatment (which may be reasonable or due to the pathology of the personality).  2. Very strong fear or anxiety.  3. Craving for drugs, substance withdrawal syndrome.  4. Delirium or dementia  5. Psychosis or paranoia.  6. Bonds from outside the hospital (e.g. looking after children, work, date, pet left alone).  7. impatience or good condition  **I./2.10.2. Avoiding the termination of clinical treatment despite doctor’s advice using psychotherapeutic tools**    The first and most basic psychotherapeutic intervention is emphatic discussion, during which we empathically listen to the patient’s subjective point of view and to what disturbs them. An empathic dialogue gives opportunity to the patient to ventilate their frustration and to feel they are being understood. Listening emphatically often dramatically decreases patients’ temper and makes it possible for the patient to agree to resume the treatment.  **Method:** Empathic mirroring of the patient’s emotions, expression of sympathy.  Having understood the patient’s subjective reasons for the termination of clinical treatment, the practitioner can help colleagues in the department as well, to understand the patient better and be able to keep adequate contact with them. Therefore, the practitioner’s psychotherapeutic activity is double-sided. On the one hand, there is the understanding and the treatment of the patient, on the other hand, there is the task of informing staff and improving the relationship between the patient and department staff, perhaps by listening to staff members’ complaints emphatically.  **Recommended Interventions:**  1. Threatening to abandon treatment at the hospital should be considered as a conversation gambit and we should try and find out what it refers to. Does the patient really want to leave or are they only expressing their frustration, anger, anxiety or other emotions this way?  2. If the patient is rightly angry, then we should apologise on behalf of the department or hospital and acknowledge that they are rightly angry and recommend some solution to the problem.  3. Avoid threatening techniques, as they usually increase emotional tension and hinder the patient in rational decision-making.  4. Adopt interventions to the patient’s personality style.  5. In case we suspect comorbid psychiatric illness, ask for psychiatrist’s help, recommend psychiatric treatment.  6. Calling in social support (family, friends), but only in case they agree with the treatment. In many cases, the family objects to certain interventions due to lack of information, cultural, religious or solvency reasons. In such cases, discussion, orientation, education or psychotherapeutic intervention involving the family becomes necessary.  7. Make sure the patient has been properly informed about the nature of their illness and the necessary treatment.  8. If there is suspicion that the patient’s mental condition is so serious (suicide intent, psychosis, dementia, delirium etc.), that they do not have insight and cannot make a reasonable decision, then a psychiatric specialist has to be consulted for judgement. It may be necessary to restrict the patenient’s freedom by legal means.  9. If, despite the doctors’ advice, the patient still abandons the hospital, they should be encouraged to return if they change their mind and decide to continue the treatment at the institute.    **Reading**  GROVES, M. S. and MUSKIN, P. R: Psychological Responses to Illness. In: Levenson, J. L. Editor. Textbook of Psychosomatic Medicine. Washington DC: American Psychiatric Publishing, 2005: 67-88. |
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