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Health Psychology Paradigm Shift in the Hungarian Rehabilitation Psychology and Clinical Special Education

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Abstract

Aim: The aim of this study is to provide readers with insights into the paradigm shift that has occurred and is still ongoing in the field of clinical psychology in Hungary over the past 20 years, particularly in relation to rehabilitation.

Methods: This study is a theoretical overview that offers a new perspective on the relationship between rehabilitation psychology, health psychology and clinical special education. It processes and compares Hungarian-language studies of the past 20 years with some recent English-language studies.

Results: I do not aim to achieve this by describing methods or empirical research but by using examples and insights from practice, primarily from key clinical areas where special educators are involved in rehabilitation teams.

Conclusion: This text demonstrates how current factors can shape professional diversity in the field of clinical rehabilitation, and how the long-discussed issue of multidisciplinarity and interdisciplinarity, have become more prominent. These changes, resulting from the paradigm shift, also significantly affect the work of special educators within clinical teams.

Keywords: Rehabilitation psychology, health psychology, clinical special education, multidisciplinary team, resilience, social support

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1. Introduction

This paper outlines the paradigm shift in rehabilitation psychology and explores the relationship between clinical special education and health psychology, focusing on both shared activities and the significance of collaborative teams (Csabai, Molnár, 2009). In doing so, the study serves as a historical interdisciplinary overview and summary, presenting multiple perspectives with the ultimate goal of emphasising multidisciplinary and interdisciplinary efforts and encouraging reflection on methodological issues at the onset of a paradigm shift (Riskó, 2015). Therefore, it is essential to first explain the concepts of clinical special education and rehabilitation psychology, before introducing health psychology and its growing prominence within rehabilitation psychology-a development that also influences the perspective of clinical special education. This task is relevant for all professionals working in both special education and psychology, whether in higher education or in diagnostic and therapeutic settings. This manuscript was not created to define the speceific roles of professionals from various disciplines or to offer practical advice. On the contrary, it approaches the subject from the perspective of rehabilitation psychology, continuing with the development of health psychology, as these fields have experienced the most significant paradigm shift over the past decade and a half.

2. Material and methods

In the theoretical part of the study, I employed the method of descriptive categories and pillar questions as the conceptual framework for the analysis. Specifically, I examined studies in which rehabilitation psychology, health psychology, and clinical special education intersect, with a focus on prioritising interdisciplinarity. Following the introduction of the historical context and paradigm shift, I based my analysis on key questions and concepts, the synthesis of which included coping with stress, resilience, and social support. The practical sites briefly presented in the study were determined by the pillar questions listed above, as these locations have seen the most significant positive changes in the cooperation of rehabilitation professionals in Hungary over the past 1-2 decades. The criteria for literature selection were therefore grounded in the previously mentioned description. Clinical special education was established as a legitimising concept at the 2003 III Educational Science Conference (Oct 9-11, 2003, "The European Learning Space and Hungarian Educational Science," MTA Pedagogical Committee, Budapest). Its key issues include: addressing disability at the functional and ability system levels; defining and tracking conditions; methodological concerns in case investigation; diagnostic possibilities; applying prevention and intervention strategies; cognitive, artistic, social, and behavioral therapeutic models; performance and ability testing procedures; analysing of effects, developing special educational protocols; presenting special forms of outpatient care, habilitation, and rehabilitation in institutional settings; evaluating the rehabilitation process; providing special educational counseling and family care; and examining special educational teamwork and supervision. The professional scope of clinical special education spans general special educational sciences, psychology, cognitive neuroscience, as well as health and multidisciplinary medical sciences (Gereben, 2004). The relationship between clinical special education and health psychology was not addressed in this study 20 years ago. However, before clarifying this concept, it is necessary to first define another key term. The term “rehabilitation psychology” has not yet become widespread in Hungary. It encompasseses the collaborative work of professionals in fields such as geriatrics, pediatric neurosurgery, neuropsychology, cardiology, neonatal care, as well as musculoskeletal, oncology, pulmonology, psychosomatic, and psychiatric rehabilitation. Proponents of "good enough" theories may be professionals who apply systemic thinking and holistic care, integrating the often-fragmented rehabilitation efforts within the team (Riskó, 2015). Rehabilitation psychology can be positioned at the intersection of clinical, social, occupational, and health psychology. As a relatively young field, it is important to review its brief history and key principles, which fundamentally shape the rehabilitation perspective.

2.1 The History, Perspective, and Main Principles of Health Psychology

In Schoefield's 1969 study, it was noted that psychologists were unprepared to address issues beyond the purely psychological. They lacked experience in areas such as preparing for surgical interventions, managing psychological stress following accidents, or contributing to rehabilitation efforts, where they could provide competent assistance (Kállai et al., 2021). This crisis was further exacerbated by the inability to move beyond the dualistic view of body and mind, which was rooted in the pathogenetic approach. Psychosomatics attempted to resolve this issue, being to propose psycological processes behind physical diseases. One of its most influential representatives in the 1950s was the Hungarian-born Franz Alexander. A new era in psychosomatics and a completely new way of thinking emerged with George Engel's 1977 biopsychosocial model. According to this model, intrapsychic conflicts were seen as just one aspect of diseases (Kállai et al., 2021). By the late 1960s, cardiovascular diseases, cancer, and accidents had become leading causes of death, making chronic diseases the primary concerns in medicine. The traditional biomedical model could adequately explain the significant rise in these conditions or the

healing process. As a result, there was a growing emphasis on identifying the behavioral patterns associated with disease processes.

The health psychology approach outlined the mapping risk and protective factors, as well as the empirical study of personality traits that influence the course of the disease (Kállai et al., 2021). In this context, we can also observe that changes that have occurred in special education in recent decades. The three-part model has gained prominence, both in the renewal of classification systems (e.g., the International Classification of Functioning, Disability and Health, 2009) and in systems-oriented intervention techniques. The approach of health psychology is closely aligned with the positive psychology movement, which seeks to uncover individual resources and strengths that can be relied upon in the coping process. Methodologically, it primarily employs cognitive and behavioral therapy techniques. In its empirical studies, health psychology focuses on the individual's experiences, attitudes, cognitions, and behaviours (Paksi, 2010).

The emergence of health psychology can be traced back to the 1970s. While the ideas of positive psychology had long been present in the field, they gained increasing attention after World War II and became an independent movement in the 1990s. Prominent representatives of this movement included Mihály Csíkszentmihályi and Martin Seligman. According to their views, it is not only important to uncover what does not function well in the personality, but also to identify the strengths on which therapy or development can be based (Csíkszentmihályi, 2004).

In both prevention and intervention, the primary focus is on mapping protective factors and developmental potentials. The spread of health psychology has also led to a shift in perspective within rehabilitation psychology, as it now addresses not only health and healthcare, but also the psychological aspects of specific disease processes.

As a result, it emphasises prevention, education, and conscious, active coping in the fight against and coexistence with illness. The focus shifts to turning inward, toward one's own body, seeking social support, and relying on others, which brings up issues of control and autonomy. In the etiology of diseases, the sense of control over one's condition is of crucial importance.

However, the rise of chronic diseases alters this perspective (Riskó, 2015). That is, disease is not solely caused by external factors, but rather develops within a framework of internal psychological and social factors. Health behaviour, therefore, encompasses all actions an individual believes will help maintain their health, recognise their illness, and prevent further disease development. It includes all behaviours the individual engages in to seek the treatment they believe is most appropriate and effective for themselves (Kaptein, 2022). Instead of the traditional biomedical model, which positioned the sick, disabled, and impaired person in a passive and vulnerable role, the biopsychosocial model has become the dominant perspective in both health and rehabilitation psychology. This new approach is often referred to in the literature as the empowerment concept (Tiringer, 2007).

Seligman's 1975 theory suggests that learned helplessness occurs when a person perceives a situation as unsolvable through active behaviour, leading to passive, avoidant responses and significant negative physiological changes. In contrast, Rosenbaum's (1988) concept of learned resourcefulness emphasises the skills and processes that regulate behaviour, focusing on personality factors that influence coping effectiveness by selecting the most appropriate coping strategies (Urbán, 2022). Health psychology has also brought a significant shift in perspective within rehabilitation psychology, with an increased focus on concepts such as coping with stress, resilience, and social support. These concepts will be explored in more detail in the following pages.

2.2 Coping with Stress

The first crisis is the illness or injury itself. During this time, the patient experiences a strong mix of despair, confusion, shame, guilt, anxiety, and fear, which can also affect the parents in the case of children. Initial denial is often followed by anger and sadness.

Overcoming the crisis is marked by the gradual acceptance of what cannot be changed, the reorganisation that follows, and adaptation to the new task. The crisis ends with confronting the precise diagnosis, accepting and adapting to the new state, and finding new meaning in life (Kálmán, 2004). The classification of coping strategies is diverse. One approach categorises them based on their success, distinguishing between adaptive and maladaptive coping strategies (Oláh, 2005).

2.3 Resilience

Resilience, also known as mental toughness, has been a subject of research for developmental psychologists for many years. It has been observed that many children who grew up in difficult life circumstances remained psychologically healthy. Researchers began searching for the personality traits that help maintain "health" and for protective factors that support resilience, such as supportive relationships (Campbell-Sills et al., 2006). More recent theories suggest that resilience is a combination of constitutional variables (temperament, personality) and specific skills (active problem-solving) (Kállai et al., 2021).

These factors work interactively to enable adaptation (Paksi, 2010). Resilience is a dynamic process made up of multidimensional factors that allow individuals to positively adapt to unfavorable life events. In this sense, resilience is negatively related to neuroticism

and positively related to extraversion. According to Bonanno (2004), it is more than recovery from trauma; it is a form of positive growth that contributes to maintaining psychological health. People with resilience typically exhibit the following characteristics: they believe they can control or influence events and perceive changes as challenges rather than threats (Urbán, 2022).

2.4 The Role of Social Support in Coping and Rehabilitation

It is now unquestionable that one of the key elements in coping with stressful situations is the presence and quality of relationships with others. The positive impact of social support on health and its beneficial effect in coping with diseases were initially supported by direct observations and later by empirical research. For example, studies have shown that social relationships trigger biochemical changes in the body, and their absence leads to a decrease in immune activity (Kállai et al., 2021). Providing help has multiple dimensions, which vary in their usefulness. The most obvious manifestation of social support lies in family relationships.

Close, positive family relationships have health-preserving effects and, in the case of illness, promote coping and survival. (Negative family relationships, of course, also affect health, but in the opposite direction: they can become a source of chronic stress, potentially leading to physical symptoms.) There are gender differences in the presence and effects of social support.

Women generally establish social relationships more easily and receive more support from them; they are more open to both accepting and offering help. Men, while often having a broader social network, tend to have more formal relationships that are less open to mutual support (Paksi, 2010).

In practice, the most constructive and developmental forms of support for an individual include emotional support—the "trio" of love, acceptance, and care, along with listening and actual presence—while instrumental support, such as financial and informational support, as well as encouragement and recognition, can also be helpful.

The least helpful interactions are typically advice or information not provided by professionals, which often generate feelings of shame or incompetence in the patient.

Therefore, the task of professionals working in rehabilitation is to assist patients in utilising their social resources. Special attention should be given to identifying the extent of the social support surrounding the patient, as well as expanding and developing these factors. This protective effect is crucial in the rehabilitation of chronic diseases. We must encourage greater involvement from patients in managing their illness and coping with the challenges presented by the disease. A supportive, empathetic, and nurturing environment enables the patient to freely express and release their pain, hostile feelings, and receive guidance and support through positive reinforcement. The supportive process fosters the use of healthy coping strategies and serves as a sustaining force against the urge to withdraw (Winston et al., 2020).

3. Results-Health Psychology Approaches in Clinical Rehabilitation Settings

In the following pages, I will introduce some clinical rehabilitation settings as examples, focusing on activities where the health psychology perspective can be applied.

3.1 Post-Stroke Patient Rehabilitation

A common issue affecting the majority of stroke patients is severe depression and low mood. Post-stroke depression (PSD) is a frequent complication that is therapeutically manageable. This phenomenon is caused by the sudden onset of neurological symptoms, along with psychological reactions triggered by the disruption of normal life.

However, it is important to note that there is no direct correlation between the severity of mood disturbances and the neurological symptoms (Antus, 2010).

Another factor contributing to PSD is biological: damage to brain structures disrupts the balance of neurotransmitter systems associated with these areas. The third component is the patient's premorbid personality. In addition, as previously mentioned, the social support system plays a significant role. According to some studies (Pataky, 2002), 60-80% of caregivers experience varying degrees of mood disturbances, which is a significant risk factor for rehabilitation.

When a patient can relate their stroke to something, such as finding an explanation for why the injury occurred and why it happened at that specific time, their chances of recovery improve. This is referred to as a naïve illness theory, which, if not irrational, can cause much less internal tension for the patient.

While we can assist in this process, it is ultimately up to the patient to develop their interpretation framework. We must support them in finding it, but the final understanding and acceptance must come from them, and we must respect their process.

Improvements in speech comprehension and production also have a significant impact on interpersonal relationships, as aphasia is a communication deficit. As the patient's independence increases, they experience a sense of success, can express their will, share their opinions, and communicate their feelings. This progress also facilitates the work of the rehabilitation team.

A key element of the health psychology approach is for team members to reduce negative experiences stemming from a sense of failure by selecting exercises that align with the patient's capabilities, while also considering their tolerance for failure.

The optimal difficulty of tasks is one that challenges the patient, but remains solvable most of the time (Pataky, 2002).
It is also essential that, throughout the rehabilitation process, the patient continuously evaluates their own performance, adjusts their expectations according to their altered capabilities, and sets achievable goals. The rehabilitation outcome will be more satisfactory for the patient if they let go of plans that exceed their current abilities and stop comparing their performance to their past self. Instead, they should adjust their expectations in line with their changed abilities (Antus, 2010).

3.2 Oncology Patient Rehabilitation

The goal of psycho-oncology is to provide patients with the capabilities and resources necessary to cope with their disease and improve their quality of life, with a focus on the pursuit of "health" (Horti & Riskó, 2006).
The task is not to directly influence the cancer itself, but to enhance the patient's self-awareness so they can mobiliseg their own strengths in service of healing. Additionally, assessing the psychosocial situation of family members, providing psychological support, and improving the psychological atmosphere within the healthcare team are also key. Social, relational, and societal disruptions are often more difficult to face than the cancer itself. Oncology patients typically fear pain, loss of bodily integrity, dependency, and death.
Critical psychological moments include the delivery of the diagnosis, the start and end of therapy, and moments of follow-up care.
Later, issues such as recurrence, metastasis, the end of active therapy, and, when necessary, the transition to palliative care, become significant psychological milestones.
Patients who are active, possess good problem-solving skills, are more flexible, and maintain a positive outlook tend to have higher survival rates. In contrast, individuals who use avoidance strategies, are more passive, and exhibit poorer mood indicators, often face greater challenges. The primary goal of health psychology in this context is to foster active coping mechanisms, which can significantly improve a patient's quality of life.
Ambulatory treatments and home care are becoming increasingly common in oncotherapy, making family members active participants in the healing and rehabilitation process. Psychological reactions will affect them, and their responses will, in turn, influence the patient.
In family relationships, communication and emotional expression should be encouraged and made more open, as this can help foster a more effective supportive environment. The rehabilitation team can provide models of coping and reinforcement for the entire family.

3.3 Rehabilitation in the Neonatal Intensive Care Unit (NICU)

Today, as the number of preterm births rises, more research focuses not only on the developmental capabilities of preterm infants but also on the mother-father-child triad and the psychological state of the mother. The mutual attunement of family members directly influences the infant's development (Hámori, 2005). Preterm mothers are more likely to experience anxiety, stress, and mood disorders.
Prolonged separation, hospitalisation, and the preterm infant's unique physical and interactional characteristics can further affect the mother's sensitivity toward her infant. The mother-child relationship is more vulnerable to postpartum conditions, which can increase the risk of later attachment or anxiety disorders compared to full-term infants (Hámori, 2005; Helle et al., 2016).
These risks are compounded by additional factors during the perinatal period, such as the mother's personality traits, her relationship with her parents, lower socio-economic status, relationship difficulties, and previous miscarriages.
The Close Collaboration with Parents Intervention Program was established at the NICU department of Turku University Hospital in Finland and was later introduced in 10 preterm birth centers across the country.
The international training for this program began in Norway in 2016, and certain training elements were later introduced in Hungary in the following years (Björkroth et al., 2019; Toivonen et al., 2020). From a health psychology perspective, it would be beneficial to expand this training in Hungary as well.
The time a child spends in the perinatal intensive care unit should be viewed as a rehabilitation period for the parents. During this time, parents can (re)learn how to adapt to their preterm child's specific needs, acquire new competencies, and receive support in processing losses and developing new coping strategies (Törzsök-Connolly, 2022).
The approach to diagnosis and therapy with children significantly differs from working with adults. Treatment must be implemented within the family environment, and the client is not solely the child but also the family as a whole. One key specificity of pediatric rehabilitation is that cognitive development and learning abilities are most intensively shaped during childhood. In complex rehabilitation, the primary focus should be on developing motor functions and addressing communication and psychological disorders (Szászi-Szrenka & Dóczyné Nagy, 2021).
In pediatric therapies, finding the balance between motivation and indication is a particularly sensitive issue. Whose motivation drives the treatment, and what should the indication be when the client is the entire family? Who sets the therapeutic goals?

In whose interest is the behaviour change? Both the child and the parents are undergoing a crisis.
The fear of the future and the grief over the "desired future" often become prolonged and difficult processes. Therefore, it is crucial to support the family itself during rehabilitation (Kálmán, 2004; Vekerdy-Nagy, 2019).

4. Discussion

In rehabilitation programs, both psychologists and special education professionals play crucial roles in the assessment and therapeutic processes. During the assessment, mapping the psychological and cognitive state not only records the current condition but also provides valuable information for developing the rehabilitation plan. This is achieved through symptom assessment scales and psychodiagnostic tools. The rehabilitation protocol (23/2006 /V.18. Ministry of Health Regulation in Hungary) primarily highlights the psychologist's role in facilitating the acceptance of the condition, in addition to the assessment. However, rehabilitation psychology can contribute much more at every level and aspect of the rehabilitation process (Szegleti, 2022).
In Hungary, as demonstrated by several international examples, there is urgent need to apply these experiences and establish a service system with a broad scope that is already operational and proven internationally.
This system should ensure that the additional services provided by the multidisciplinary team are not funded for a single period, but rather in the long term, through normative financing. In a multidisciplinary approach, the health psychologist must always be a member of the professional team.
Additionally, it is clear that the care of chronic diseases through a complex, interdisciplinary approach has been established for decades in some countries, ensuring the timely recognition and treatment of psychological issues.
This integrated approach requires the presence of well-trained, cooperative professionals, where psychological sensitivity and openness to a comprehensive approach are expected from all team members, not just the psychologist. It is most effective when information about the clients' condition is shared continuously among the team, and when all team members approach the client with a unified attitude (Bechtold & Mikesell, 2025).

5. Conclusion

The guidelines of the Health Psychology Section of the British Psychological Society (2025) emphasise the critical role of health psychologists in rehabilitation and prevention.
Health psychologists are skilled in applying psychological knowledge, which enables them, among other things, to develop and implement interventions aimed at improving self-care for patients with chronic conditions and supporting the development of healthy behaviors. In their work, they collaborate with hospital professionals, patients, their families, and professional organisations. They provide long-term care for patients with physical symptoms and assist with self-management.
They can also make recommendations for the development of healthcare systems, provide information and advice to both professionals and the general public, conduct research, and base their everyday practice on scientific evidence.
Additionally, they are involved in education and communication, preparing patients for surgery to help them cope with the psychological challenges of the procedure, and fostering trust between the doctor and patient during rehabilitation (Lund et al., 2025).
Introduction to Low Intensity Psychological Interventions (LIPI): These interventions involve brief steps that can be applied in practical care, incorporating techniques such as motivational interviewing and behavioural activation in rehabilitation (Chambers et al., 2014).
Rehabilitation should focus not only on visible physical difficulties but also on the less obvious psychological processes that hinder an individual's reintegration (Szegleti, 2022). Residual symptoms affecting communication can significantly impact social relationships and, in children, their school performance. In these cases, avoiding failure and isolation becomes a primary therapeutic goal.
It is essential to emphasise how symptoms and residual symptoms affect the individual's self-esteem and emotional well-being.
The aim should be to help individuals set realistic goals that shape their future, rather than focusing solely on what has been lost. One limitation of this study is that the clinical settings mentioned are involved in different rehabilitation tasks, making it difficult to speak of a unified health psychological approach. Additionally, there are several other important areas of rehabilitation practice that were not addressed.
Future work should focus on defining the role of health psychologists within rehabilitation psychology more precisely and in greater detail, particularly in Hungary.

Conflict of interests

The author declares that there is no conflict of interest. No financial interests are reported.

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