

The Biopsychosocial Model of Treatment the Patients with Inflammatory Chronic Bowel Disease

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ABSTRACT

We present the organised psychological group interventions for persons with inflammatory bowel disease (*ulcerose colitis*, *Morbus Crohn*). The actual bio-psychosocial model of health and illness is used to explain the situation of chronically ill patient as stressful life position and their ways of coping with such, health-related problems. Considering that numerous psychological factors can lead to insufficient illness adaptation and (non) adherence to treatment – and all those – to much more complications and higher use of therapies, we try to develop for group of those patients effective model of treatment. The group of 15 gastroenterological patients from treatment in UKC Maribor was included in the psycho-diagnostic procedure (semi-structural interview, *The Freiburg's Personal Inventory*, *The Coping Inventory for Stressful Situations*, *Health-related Questionnaire of Quality of Life*). The data that we had been gathered were significant to the C-type of coping, found in some other group of chronically ill patients, too. For such persons is typically their low emotions expressiveness, especially negative emotions (*sadness*, *anger*). In interpersonal contacts they usually show extreme social agreement and low level of assertiveness. So we formed our therapeutic model and its therapeutic aims to the course of being able to express the emotions, to reach higher personal autonomy, better assertively and self image – which at the end have all greater influence on the human's quality of life. After therapeutic model and aims of treatment has been formed, patients with inflammatory bowel disease were treated in cognitive-behavioural group, where also C. Roger's conditions for successful psychotherapy were taken in account and were the part of hole, integrative form of treatment.

Key words: *chronically ill-patient, stress, coping, group treatment*

Introduction

Psychological models of chronic illnesses

Chronic illnesses are disorders which persist for an extended period of time and are either incurable or result in pathological changes which limit a person's ability to function daily in a normal way. Due to improved public health and to better medical control over acute infectious diseases and to the increased life expectancy of population associated with it, during the 20-th of century chronic diseases have become important health risks in Western societies (e.g. Glasgow et al., MacKeown, 1979). It is estimated that at any given moment 50 per cent of the population suffer from a chronic illness requiring some form of medical intervention (Taylor, Aspinwall, 1996). Most chronic illnesses occur in older adults; and as the

average age of the population increases, so does the prevalence of chronic illnesses. Most chronic illnesses have a late onset (people aged 60 and older), but some, such as asthma and diabetes, may even manifest themselves in young children (Suris, Blum, 2001).

From psychological point of view, a wide variety of diseases which have in common that they are of a long-lasting nature, may be of interest, possibility affecting patients' willingness and ability to perform behaviours related to managing illness and adhering to medical prescriptions. From that point of view it is important to discriminate between different categories of chronic illness.

Such characteristics as predictability, contagiousness or the life-threatening have been proposed as factors possibly affecting illness management and support from relatives and friends (Felton, Reveson, 1984, for example, cancer and AIDS). Another characteristic of interest relates to control-ability of disease, referring to the actual possibilities of influencing the symptoms and course of the illness by performing self-care behaviours. Typical diseases which are controllable by the patients are diabetes and asthma, typical uncontrollable diseases are neurological disorders such as multiple sclerosis is. While maintaining a healthy diet or adjusting medication leads to the problems of discipline and self – government, uncontrollability of illness may result in feelings of helplessness.

Psychological studies on chronic illness guided to three major models of the role of personality in chronic illness: the stress moderation model or health-protective/health damaging model, health behaviour model and illness behaviour model. These three models suggests that personality exerts its influence on health and illness through processes, such as appraisal of stress and subsequent coping responses are, through the influence of health behaviours to the onset of illness or through the tendency to perform illness-relevant behaviours when one ill is, too¹.

Illness processes that have captured the interest of many clinical researches are inflammatory bowel diseases as ulcerous colitis and Morbus Crohn are, and so was, as we will later see, also in our case.

Stress, emotions and coping process

Recent research finding the role of personality in dealing with stress fit into a broader framework highlighting the role of emotions in the onset of chronic illness. There is accumulating evidence that repression or inhibition of negative emotions may be risk factor in the onset and course of chronic diseases (Traue, Pennebaker, 1993). But not only the stress and its related emotions are important, most research on psychological issues in chronic illness has not been concerned with their role in disease onset but with adjustment to illness – most interesting is not only the stress but how the patients see their health-related stress position and how they cope with them¹.

The concept of coping was best defined in years 1978 and 1984 by work of Folkman and Lazarus as the process of constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person. It is the series of transactions between a person, his/her personality (hardiness, optimism, psychological control, self-esteem, ego-strength etc.) and a particular environment with its own resources, demands and constraints (time, money, education, standard of living, social support, absence of other life stressors etc.). The nature of the event also contributes heavily to which sort of coping strategies will be used, too. So work-related problems lead people to attempt problem-focused coping ef-

forts, health problems, in contrast, lead to more emotion-focused coping and to more seeking the social support, where it may be both, a case of adaptive behaviour coping pattern («I talked to someone to find out more about the illness») or only the form of momentary need of emotional ventilation. Perhaps, it is so because a treat to one's health is an event that must be tolerated but is not necessarily amenable to direct action (Vitaliano et al., 1990). F. Cohen and Lazarus (1979) suggested that coping efforts center on five main tasks:

- To reduce harmful environmental conditions and enhance the prospects of recovery,
- To tolerate or adjust to negative events or realities,
- To maintain a positive self-image,
- To maintain emotional equilibrium,
- To continue satisfying relationships with others².

Lazarus and Folkman (1984) first proposed that coping consists of two general dimensions as problem-focused coping and emotion-focused are and where coping efforts may be directed at solving a problem or at regulating emotions. Later they (1988) described eight distinct coping strategies: three factors as the confronting coping, seeking social support, and planning problem-solving are most clearly related to the problem-focused coping and four others as self-control, distancing, positive reappraisal, accepting responsibility and escape/avoidance strategies are most frequently related to the emotion-focused coping^{2,11}.

Researchers attempted to define successful coping with respect to a variety of outcomes.

So, at first, coping efforts are really judged to be more successful if they reduce arousal and its indicators (heart rate, pulse, skin conductivity etc.). A second criterion of successful coping is whether and how quickly people can return to their activities. But it is not always true, for example, a sick person who is overworked and hates his job may not be showing successful adjustment if he returns to the same work situation; revising the work situation would be a more successful form of coping (Taylor, 1983). Finally, and most commonly, researchers judge coping according to its effectiveness in reducing psychological distress (when a person's anxiety or depression is reduced, the coping response is judged to be successful). If coping is really successful must be judged according to a number of different criteria. For example, if one has a heart attack, it is not adaptive to ignore or avoid this. While in the hospital, it may be adaptive to avoid focusing on the heart attack and instead focus on recouping one's energy and getting better. However, the avoidance behaviour may be maladaptive if, in the long term, a person continues to avoid confronting the problem and does not change his or her lifestyle².

In our case we were interested in testing personality resources to cope with illness-related stress. We know that some of these intensify the experience of stress, whereas others reduce it. Some of these exacerbate the links between stress and illness, whereas others may be regarded as protective against illness in response to

stress, too. So we collected the data and regarding to these we were able to develop the model of treatment specific chronically ill persons and then to put the therapeutic goals and the ways to manage the illness situation more effectively.

Health-related quality of life

In last decade of 20-th century most changed patterns of illness, the prevalence of chronic illness, coupled with advancing medical knowledge, have increased the number of psychological and psychosocial questions and confirmed the necessity of the bio-psychosocial view. Many chronic diseases, typically diseases that can not be cured, but rather only managed by patient and practitioner together, affect all aspects of patient's life (Burish, Bradley, 1983; Taylor, Aspinwall, 1990). Immediately after a chronic disease is diagnosed, patients are often in a state of crisis marked by physical, vocational, social, psychological disequilibrium (Moos, 1977). Physically disabled chronic patient often may need to restrict or change their work activities. Some may be moved into less demanding position with lower incomes (Taylor, 1995). Such alterations of daily functioning and style of living lead many chronic patients to higher levels of anxiety, overall distress, depression and even thought of suicide, especially when also their social relationships, intimate and distant, are altered (Fitzpatrick, Newman, Lamb and Shipley, 1988; Dakof, Taylor, 1990; Stein, Gordon, Hibbard and Sliwinski, 1992, et.) and when the chronic illness and its treatment produce drastic changes in patient's self-concept and self-esteem (Richardson, Goodman, Hastorf and Dornbusch, 1961; Gates, 1974; Kahn, 1981; Lichtman, 1982; van Lankveld et al., 1993; et.)³.

While the primary outcomes of interest in health-care evaluation have traditionally been mortality and morbidity, the past decades have seen a dramatic increase in identifying the impact of interventions on function and QoL. So, also among health care specialists were growing awareness that quality of life is important health outcome in assessing the functioning of the chronically ill.

Quality of life (QoL) may be defined as a person's sense of well-being that stems from satisfaction or dissatisfaction with the areas of life that are important to him/her (Becker et al., 1993) or more generally and phenomenological that it is what the individual says it is. (Joyce, 1988). It is not a new concept, much of pioneering work was undertaken by Thorndike, as early as in 1939, however, it is a rapidly expanding area with over 1000 new article indexed each year under the heading »quality of life« (Muldoon, et al., 1989). Health contributes to quality of life and the true impact of health and disease on quality of life is known as health-related quality of life (HR-QoL). It is generally considered to have several components. The basic dimensions of health-related quality of life are physical status and functioning, psychological status, social functioning, and disease- or treatment-related symptoms (Coons and Kaplan, 1992). In addition, there are quality of life measures that have been developed for specific diseases, such as cancer (The Cancer In-

ventory of Problem Situations, Schlag, Heinrich, Aaland and Ganz, 1990; Karnovsky Performance Scale, Grieco and Long, 1984) or ulcerative colitis and Morbus Crohn are (The Rating Form of Inflammatory Bowel Disease Patient Concerns, RFIPC, Drossman et al., 1991)^{4, 5}.

In our case we used IBD-QoL Questionnaire in combination with other measures (Coping and Personal Traits Questionnaires) to assess how and how much ulcerative colitis and Crohn's disease affect patient's general activities of daily living, vocational and social activities, distant and intimate relationships, self-image, especially, body image.

Psychological interventions

A number of psychological interventions targeted at individuals diagnosed with chronic illness. The interventions considered are the provision of information, stress management training, self management training, the provision of social support, written emotional expression. All of these interventions have proven effective when used in the context to which they are best suited. All have been less effective when used without due consideration to the target population or the goals of intervention.

Where the intervention goal is one of behavioural change, programmes that teach skills and actively consider how they can be applied in the real world of individual are more likely to be effective than those that provide didactic information only. In addition, the outcomes of interventions are generally specific to the goals or the content of that intervention. So educational programmes can impact on how well people manage their illness – as well as more complex interventions. The majority of studies have shown that didactic educational programmes may be less effective than more interactive or skill-based programmes, even where increases in knowledge are achieved (Bennett, 2000).

Information can be proved in a number of ways: verbally within a consultation or series of educational meetings, written booklets and handouts, audio-or video-tapes, or via computer interface. There is a wealth of evidence that poorly presented information is of little or no benefit to those receiving it. So Ley (1997) founded that about quarter of published medical leaflets would be understood by only 20 to 30 per cent of adult population. Over three-quarters of patients' state they would like some form of permanent information about their condition and its treatment: preferably concise, clear, using appropriate language and syntax, and illustrated with graphics. Verbal information may be usefully augmented by written material. If provided, about, 70 per cent of patients report using such materials⁶.

The stress management programmes (relaxation training, cognitive interventions, Meichenbaum, 1985) may changes the levels of the stress and are therefore frequently used with populations considered to be under stress as a consequence of their diagnosis or the illness process. Focusing on the most important elements of the stress model, stressors-appraisal-coping-social support-

-strain, there is potential for intervention at all of these levels, as is discussed below:

Stressors – this step requires a careful assessment of the stressors the patient is exposed to. With training the patient may be better prepared for new conditions or in other cases; assertiveness training may be effective in helping individuals to protect themselves from overload.

Appraisal – people are not always realistic in their perception of events, as consequence, basically neutral stimuli may be appraised as stressful.

Coping – there is some evidence that people with rigid coping style, who lack the flexibility to try different ways of dealing with stressors, run higher risk of developing stress symptoms (Lester, Smart and Baum, 1994). Flexibility may, therefore, also be an important focus of assessment.

Social support – on the basis of the proper assessment of social support it is possible to determine whether or not it is necessary and how to intervene in order to facilitate the receipt of social support, be it formal or informal. Learning social skills may be very helpful for some individuals lacking social support.

Combating stress symptoms – there is a wide variety of techniques aimed at facilitating relaxation, systematic desensitization, autogenic training, meditation, yoga, self-hypnosis, etc. Whereas all of above forms of interventions mainly focus on the individual, may also be applied to groups, organizations, or society at large⁷.

Behavioural skill training results in skill changes, cognitive reconstructive treatment can evoke and change patterns of emotional, cognitive and behavioural reactions, it may interrupt the flow of stress-provoking thoughts and replacing them with more effective coping ones. Much of such treatments are based on the self-regulation model of illness cognition and behaviour developed by Leventhal (2001) with five key components of illness representations: illness identity beliefs, cause, time-line, consequences and control or cure beliefs. Identity beliefs (illness label and symptoms) influence decisions to seek medical care for symptoms, and inaccurate labelling of symptoms and can lead to inappropriate use of medical services, such as delaying to seek care for symptoms associated with life-threatening conditions. Causal beliefs vary in terms of their locus, internal or external, stability and controllability, where are internal, stable and controllable causes often associated with more active, problem-focused coping and better psychological adjustment. Time-line beliefs tend to reflect an acute model, a cyclical model or a chronic model of the illness and so the chronic patient with acute model of his/her illness may exhibit difficulties in adhering to on-going treatment regimens. Beliefs about consequences of an illness are influenced by factors such as perceptions of disease prevalence and number of symptoms and can be important predictors of behavioural responses (use of medical services, psychological adjustment, etc). Beliefs about the controllability and curability of an illness are also related to coping behaviour and psychological adjustment and so are high

controllability beliefs mostly associated with more active coping, lower distress and better health outcomes⁸.

Social support theories are intertwined with the concept of stress and coping. The study of social relationships requires a conceptual framework that also includes activities of the recipient and the provider since support is usually not a one-way street: recipient enters a stress episode with a habitual level of perceived support. He/She may feel a need for support and start coping, which includes active seeking and mobilization of support by implicitly expressing their need or by explicitly calling friends for help. Then, the provider will comfort the person in need, give advice or donate goods. This, in turn, will be considered as received support on the part of recipient. Aldwin and Yancura (2003) point out that social support conceptualized as social integration is always associated with better mental and physical outcomes. On the other hand, seeking social support is often associated with poorer outcomes (Monroe, Steiner, 1986). The various sources (partner, family, friend, group) and kinds of social support (emotional or instrumental support given as advise, tangible assistance, information, reassurance, listening) may exert their impact on health and lifetime prolonging factors via a number of behavioural and cognitive mediators that are closely linked to immune functions and cardiovascular reactivity (Herbert, Cohen, 1993, Seeman et al., 1994)⁹.

Accordingly, a number of researchers have attempted to determine whether providing social support either through support groups or teaching people the skills to build up their own social support network can improve both well-being and influence health status. Support groups certainly appear to reduce the stress associated with long-term illnesses. So Classen et al. (2001), for example, reported on effectiveness of a year long weekly support group in which patients with breast cancer were encouraged to explore their emotional reactions to their illness and to gain support from the group. Compared to participants in a control group provided with educational materials, participants in the active intervention reported significantly greater reductions in traumatic stress symptoms and better mood in the long term⁶.

Materials, Methods and Interventions

In the group of patients with inflammatory chronic bowel disease (ulcerous colitis or Morbus Crohn), who were in the year 2003/04 diagnosed and treated at gastro-enterological department of UKC Maribor by the same doctor, 15 of them were referred also to the psychological treatment. The majority of them were women (11); the other ones were men (4). The average age was 36 (the youngest were 22; the oldest were 51 and 60). Most of them were married (6), single (6), only three were divorced or widower.

They finished vocational or secondary school; three of them were still students. Except three students and one retired patient, they have employment. Their somatic

problems lasted from two to 16 years (in average 7 years).

Preparing the patients to the psychological treatment, we started with psycho-diagnostic procedure. Beside the semi-structured interview, we used next instruments:

- The Freiburg’s Personality Inventory, FPI, short form, by Fahrenberg J et al., 1981;
- The Heath-related Quality of Life Questionnaire (HR-QoL, IBD-QoL), Drossman DA, Patrick DL et al., 2000, University of N. Carolina, Washington, Seattle and Toronto;
- The Coping Inventory for Stressful Situations, CISS, Endler NS, Parker JDA, 1990.

The Freiburg Personality Inventory, short form, is self-reported questionnaire, formed on Eysenck’s theory by Fahrenberg J, Selg H, Hampel R in years 1963–70. To purpose of Slovenian use it was adapted in 1981 by Bele-Potočnik Ž, Hruševar B, Tušak M. It consists of 9 personality dimensions and 3 scales (138 items):

Neuro-vegetative disorders, Spontaneous Aggression, Depressiveness, Excitability, Sociability, Self-control, Reactive Aggression, Inhibition, Frankness, and Extraversion/Introversion, Emotional Stability/Instability, Masculinity/Femininity scales¹⁰.

The Heath-related Quality of Life Questionnaire (HR-QoL, IBD-QoL), which authors are Drossman DA, Patrick DL et al., 2000, is also self-reported instrument. It is used for IBD patients to assess how the illness disorders (diarrhea, abdominal pain and distension, gastrointestinal bleeding, loss of energy) affected the person’s quality of life. It consists of eight sub-scales with 34 items, which have all 1–5 point scales. They are: dysphoria (8 items), interference with activity (7 items), body image (4 items), health worries (4 items), food avoidance (3 items), social reaction (4 items), sexual life (2 items), relationships (3 items).

The higher the total score is the more seriously affected the person’s life is (maximum total score is 170, minimum total score is 34)³.

The Coping Inventory for Stressful Situations, CISS, Endler NS, Parker JDA, 1990, also self reported inventory, 48 items, 5-point Likert scales, measures three main coping strategies: Task focused (dealing with problem at hand); Emotion focused (concentrating on the resultant emotions, as becoming angry or upset) and Avoidance coping (trying to avoid the problem).

Avoidance coping divided further into two types: Distraction subscale (8-item) and Social Diversion subscale (5-item)^{11,12}.

After the described procedure gathering its results for that group of 15 patients, we were able to form the therapeutic goals. We decided to organize psychotherapeutic group with five main tasks:

- to reduce harmful environmental conditions and enhance the prospects of recovery,
- to tolerate or adjust to negative events or realities,

- to maintain a positive self-image,
- to maintain emotional equilibrium and
- to maintain satisfying relationships with others.

We also chose the forms of therapies. In psychological treatment of all the included IBD patients, we planned the integrative group of psychotherapy, which would get the elements of functional relaxation therapy, cognitive-reconstructive treatment, behavioural skill training and supportive therapy. We tried to achieve by those patients next therapeutic aims:

- to offer the patients best sense of comfort, safety and physical well-being;
- to be able and win better insight into own bodies signals and their messages (hunger, thirst, tiredness etc);
- to be able and win the better insight in own feelings (fear, anger, worry, feel of guilty, deprivation, disgust, resistance);
- to be able and learn the better expressions of own feelings (anger, fear, and guild);
- to be able to recognize own internal and external conflicts;
- to reach higher autonomy and self competence.

To be successful and to reach the changes, we respected in psychotherapeutic processes these six C. Roger’s basic conditions of psychotherapy:

- Two persons are in psychological contact.
- The first person, the client, is in a state of incongruence, being vulnerable or anxious.
- The second person, termed the therapist is congruent or integrated in the relationship.
- The therapist is experiencing unconditional positive regard toward the client.
- The therapist is experiencing an empathic understanding of the client’s internal frame of reference.
- The communication to the client of the therapist’s empathic understanding and unconditional positive regard is, to a minimal degree, achieved.

As therapeutic goal was to reach higher personal autonomy and self competence, we took in account also these C. Roger’s principles of client’s growth:

- Clients are increasingly free in expressing their feelings, through verbal and/or motor channels.
- They expressed feelings increasingly have reference to the self, rather than no self.
- They increasingly differentiate and discriminate the objects of their feelings and perceptions, including their environment, other persons, their self, their experiences, and the interrelationships of these. Their experiences are more accurately symbolized.
- Their expressed feelings increasingly have reference to the incongruity between certain of their experiences and their concept of self.
- They come to experience in awareness the threat of such incongruence. This experience of threat is possi-

ble only because of the continued unconditional positive regard of the therapist, which is extended to incongruence as much as to congruence – to anxiety as much as to absence of anxiety.

- They experience fully, in awareness, feelings that have in the past been denied to awareness or distorted in awareness.
- Their concept of self becomes reorganized to assimilate and include these experiences that have previously been distorted in or denied to awareness.
- As this reorganization of the self-structure continues, their concept of self becomes increasingly congruent with their experience; the self, now including experiences that previously would have been too threatening to be in awareness. A corollary tendency is toward fewer perceptual distortions in awareness, or denials to awareness, since there are fewer experiences which can be threatening. In other words, defensiveness is decreased.
- They become increasingly able to experience without a feeling of threat the therapist’s unconditional positive regard.
- They increasingly feel unconditional positive self-regard.
- They increasingly experience themselves as the locus of evaluation.

- They react to experience less in terms of their conditions of worth and more in terms of an organism valuing process¹³.

Results

Figure 1 represents the data of the Freiburg Personality Inventory application. Group of 15 IBD patients characterized the emotional high exiting (FPI-N), higher extent of the neurovegetative, functional disorders (FPI-1), need and tendency to social interactions (FPI-5), higher tendency to be efficiently and competitiveness among others (FPI-M), but also low degree of personal autonomy, low ability to be in interpersonal relationships assertive and satisfy (FPI-3).

In Table 1, Heath-Related Quality of Life Questionnaire, we can see the level and sort of psychosocial problems in this group of included patients. The eight categories of illness related stress situations and their average values (M) and proportions (p) for each, before and after 4-months of therapeutic treatments, are present.

As we can see it, before the including in therapeutic group, the patients were ill humoured. Every thing seems to them to be crashing down, being without energy and not able to execute daily actions. It is not surprising that in that phase they tend to be alone. Because the sexual

Dimensions	M		Dimensions and standandised scores				
Nervousness	3	Neurovegetative disorders	4	3	2	1	Without disorders
Spontaneous Aggressiveness	1,6	Spontaneous aggressive	4	3	2	1	Agressiveless
Depressiveness	3	Dissatisfied	4	3	2	1	Satisfied
Excitability	2	Exitable	4	3	2	1	Calmy
Sociability	3,4	Sociable	4	3	2	1	Unsociable
Self-control	2,4	Self-controlled	4	3	2	1	Self-uncontrolled
Reactive Aggressiveness	1,1	Reactive aggressive	4	3	2	1	Indulgent
Inhibition	2,1	Inhibited	4	3	2	1	Spontaneous
Frankness	1,9	Self-critical	4	3	2	1	Self-uncritical
Extraversion / introversion	2,6	Extraversion	4	3	2	1	Introversion
Emotional Stability/Instability	2,9	Emotional Instability	4	3	2	1	Emotional Stability
Masculinity	3,3	Masculinity	4	3	2	1	Feminility

Fig. 1. The Freiburg Personality Inventory, FPI, short form. IBD = inflammatory bowel disease.

TABLE 1
HEATH-RELATED QUALITY OF LIFE QUESTIONNAIRE (HR-QOL, IBD-QOL)

HR- IBD- LoQL subscales	before treatment M / p		4 months after M / p		MIN. test value	MAX. test value
Dysphoria	35	.87	16	.40	8	40
Labour unefficiency	31	.88	19	.54	7	35
Body image	15	.75	10	.50	4	20
Worries about health	13	.87	7	.47	3	15
Avoidance of food	15	1.00	11	.73	3	15
Social reactions	14	.70	8	.40	4	20
Sexual life	10	1.00	6	.60	2	10
Interpersonal relationships	13	.87	7	.47	3	15
Total	146		86		34	170

IBD = inflammatory bowel disease

desire decreased precipitously, they were not interested to be intimate in partner relationship, too.

After 4-months of treatment, they became more optimistically, showed less illness-related worries and concerns. They are in better form, having more energy and are able to done more. However, their interest for sexual life as the predictor of interest for worth and life was still poorly. As we wanted to reach completely better mental state, after these 4-months data we continued the therapy finishing it successfully after one year of intense treatment, two hours a week each month.

Table 2 shows patients' most used coping strategies. As we can see, more than task-oriented coping (range 2) and avoidance-oriented coping (range 3), they most frequently used the emotion- oriented coping strategies (range 1). Among avoidance behaviour patterns, they usually used types of social diversion coping strategies much more than such of distraction type. The patients are occupied with various fears and worries: »worry about not being able to cope«, »worry about next step«. They put the blame on themselves: »blame myself for the situation«, »blame myself for having no solution«, »blame myself for being too emotional«, but they still try to comfort themselves: »to tell myself it will never happen again«, »tell myself it is really not happening« or »wish that I could change things«. Because of greater anxiety, they are unable to confront themselves with reality completely; often they try to get away from the problems by

turning on TV, watching films, sleeping it over or similar. Seldom they used social coping strategies as »to be with others«, »to talk to someone«, »to phone someone« or »to think about something other«.

Our observations and impression about somebody and his/her reactions in the group dynamic processes were similar as the presented data of used questionnaires showed.

As in the first phase of integrative therapy, we included the program of physical and mental relaxation (AT, PR, FR) to offer the patients the sense of safety and comfort, their confidence in therapy and therapist increased and shortly after that they show in therapeutic processes more active role. They were gradually more and more able to express suppressed emotions. With better expression of feelings, they gradually won better insight in their own emotional sphere and their interconnectedness with physical reactions. So, they got a better possibility of managing their different emotional states and the way to change their ineffective, mind and behavioural patterns, the processes of cognitive restructuring was opened.

To be in the group of persons having the similar problems as the other ones, this fact increased the feeling of social connection and the process of sliding into social isolation was interrupted. Interactions grew up the feelings of social support. Step by step IBD patients were in position to manage the illness related troubles better and to win higher level of quality of life. The therapeutic processes took the direction we wanted, toward the better management of stressful life with illness. After one year of intense treatment and after that some patients because of different reasons has left it before its ending, we could successful conclude their treatment.

Discussion and Conclusion

With the presented study we wanted to get the adequate therapeutic goals, choose the appropriate therapeutic forms and make a right decisions in therapeutic procedure organized for this group of chronic ill patient.

TABLE 2
THE COPING INVENTORY FOR STRESSFUL SITUATIONS, CISS

Coping style	MIN. and MAX. test value	Achieved values	Rang
Task oriented	16–80	46	2
Emotion oriented	16–80	66	1
Avoidance oriented:	14–70	42	3
a. Distraction	6–30	16	3.2
b. Social diversion	8–40	26	3.1

IBD = inflammatory bowel disease

The purpose of our study was therefore very practically, only to verify the psychotherapeutic treatment of this group of patients and not to make the great conclusions (considering our small sample, it can also not be accepted!).

But, in spite of a small sample and not permissible conclusions, our results show some interesting trends.

At Table 1, we can see that because of chronic illness, the patients' quality of life is at the beginning of group therapy really worse. They have to cope with many different, illness-related troubles as bowel (diarrhoea, abdominal distension and pain) and systemic (fatigue, troubles in sleep, feeling unwell) symptoms are. Therefore are in daily activity inefficiently (»I feel like I'm losing control of my life because of my bowel problems«, »My bowel problems limit what I can wear«), avoid social events (»I feel isolated from others because of my bowel problems«) and are worried, angry, aggressive, and irritable, embarrassed (»I fear that I won't be able to have a bowel movement«, »I worry that my bowel problems will get worse«). They are not only occupied with various fears, worries, they also feel guilty, but put all the blame on themselves (»I feel like I irritate others because of my bowel problems«, »I feel I get less done because of my bowel problems«). Because of bowel and systemic symptoms their intimate life and sexual life become complicated, too (»My bowel problems are affecting my closest relationships«, »My bowel problems reduce my sexual desire« or »Because of my bowel disease sexual activity is difficult for me«).

Such troubles they mostly try to manage to avoid the confrontation with the problems, to withdraw from the social life and contacts and to suppress the negative emotions.

Considering the fact that the treated persons are somatic ill, such coping have been expected. They confirm the results of many researches finding the somatic ill people mostly used to cope with the emotion-focused strategies.

Such results of coping in CISS are confirmed with the higher level of anxiety and depression we have found in FPI. If we take a closer look at Figure 1, we can see that the included persons show greater emotional excitement (higher FPI-N) and therefore also greater extent of neuro-vegetative disorders (higher FPI-1). They are sociable (higher FPI-5), but not enough autonomous and assertive. Mostly they look as unsatisfied and depressed persons (higher FPI-3).

Such results in FPI suggest that not only illness problems but also the personality traits could determined the patients' coping processes. The authors of CISS, Endler and Parker (1994) found that the Task-oriented coping had significant negative correlation with Neuroticism ($r = -.23$, $p < .01$), whereas it had a positive correlation with Extraversion ($r = .24$, $p < .01$) and Conscientiousness ($r = .35$, $p < .001$). On the other side Emotion-Oriented Coping correlated significantly with Neuroticism ($r = .063$, $p < .001$) and Psychological Distress factors of Anxiety/Insomnia ($r = .44$, $p < .001$) and Somatic symptoms ($r = .37$,

$p < .001$). Avoidance-Oriented Coping factor had notable positive correlation between Extraversion and Social Diversion coping strategies ($r = .23$, $p < .01$). Authors also found strong relationships between Emotion-oriented coping and both depression and anxiety (as state and as trait).

They have also noted that specific coping styles can either promote physical and mental health or exacerbate illness. In general, task or problem-oriented coping styles are positively related to adaptation and good health; emotion-oriented coping styles are negatively related to adaptation and good health (Clarc, Hovanitz, 1989; Endler, Parker, 1990a, 1990b, 1994)⁹.

In this way we could make the conclusion that our data from The Freiburg Personality Inventory, FPI, short form and these from The Coping Inventory for Stressful Situations, CISS, show some characteristics, which could be classified as C-behaviour type. As Nyklicek established, the persons with such type of reactions (usually described as the polar opposite of type A-behaviour) displayed most or all of the following behaviour patterns:

- The persons are non-expressers of anger. Often, they were unaware of any feelings of anger, past or present.
- They tended not to experience or express other negative emotions, namely anxiety, fear, sadness.
- They were patient, unassertive, cooperative, and appeasing in work, social, and family relationships. They were compliant with external authorities.
- They were overly concerned with meeting the needs of others, and insufficiently engaged in meeting their own needs. Often, they were self-sacrificing to an extreme.

People often embody a variety of characteristics from throughout the coping continuum of type A, to B, to C. As type A-behaviour is generally self-centred, highly charged, competitive, and overflowing with anxiety, anger, and hostility, the individual with type B- behaviour feels relaxed, expresses anger and other emotions, meets their own needs but also responds to the others. Most persons embody variety of both characteristics.

All the types of behaviour patterns and so also C type of behaviour are considered more of coping style than a personality; so many individuals who are considered type C, can also learn new behaviours. (Nyklicek I et al., 2002)^{14,15}.

And what kind of conclusions we can also made in the future?

In first line, when we next time plan the study of psychotherapy the chronic ill persons there were be better to used the test battery not only at the beginning and in the middle of the treatment but also before its conclusion. In our case we couldn't because of not equally number of patients at the start and then at the ending of therapy.

And as the P. Benett said, we also thought that the key to future interventions may be to identify the minimal intervention that will be of benefit to most patients and to provide this on a large scale, with individual health

professionals skilled in psychological therapies only becoming involved in cases where high level of expertise are required. A future strategy may be to move at least some of care of people with chronic illness away from hospital and other health care settings, and to have it more situated in the community.

Perhaps the next real challenge facing clinical health psychology is to move from the scientific study of interventions conducted in centres of research and clinical excellence to the routine use of psychological programmes within the wider health-care system. One way in which this may be achieved is to train other professions in the

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BIOPSIHOSOCIJALNI MODEL LIJEČENJA PACIJENATA S KRONIČNOM UPALOM CRIJEVA

SAŽETAK

U ovom radu predstavljamo organizirane psihološke grupne intervencije za osobe oboljele od upale crijeva (ulcerozni kolitis, Chronova bolest). Biopsihosocijalni model zdravlja i bolesti se koristi kako bi se objasnio položaj kronično bolesnih pacijenata, njihove stresne životne situacije i način suočavanja i nošenja sa vlastitim zdravstvenim problemima. S obzirom da mnogi psihološki faktori mogu dovesti do nedovoljnog prihvaćanja bolesti i (ne)pristajanja na liječenje, a sve to i do mnogo većih komplikacija i većom potrebom za terapijom, pokušavamo razviti učinkovit model liječenja za ovu skupinu oboljelih. Skupina od 15 gastroenteroloških pacijenata na liječenju u Kliničkom Centru Maribor je bila uključena u psihodiagnostički postupak (polustrukturirani intervju, Freiburški inventar ličnosti, inventar suočavanja sa stresnim situacijama, upitnik o kvaliteti života s obzirom na zdravlje). Podaci koje smo dobili bili su značajni za tip C suočavanja, ustanovljen i kod nekih drugih skupina kronično bolesnih pacijenata. Za takve je osobe karakteristično neizražavanje emocija, pogotovo negativnih (tuga, ljutnja). U interpersonalnim odnosima oni obično pokazuju visok stupanj društvenog slaganja i nisku razinu asertivnosti. Mi smo prema tome formirali naš terapijski model i terapijske ciljeve – sposobnost izražavanja emocija kako bi se postigla viša razina osobne autonomije, više samopouzdanje i bolja slika o sebi, što u konačnici ima veliki utjecaj na kvalitetu života osobe općenito. Nakon što smo utvrdili terapijski model i ciljeve liječenja, pacijenti s upalom crijeva liječeni su u kognitivno-bihevioralnim grupama, u kojima se u obzir uzimaju i uvjeti C. Rogera za uspješnu psihoterapiju te su bili dio jednog cjelokupnog, integrativnog oblika liječenja.