



Original article

Anxiety in close relationships is higher and self-esteem lower in patients with irritable bowel syndrome compared to patients with inflammatory bowel disease

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ABSTRACT

Background: Previous research has suggested an interaction between personality factors and inflammatory bowel disease (IBD) as well as irritable bowel syndrome (IBS). We therefore aimed to elucidate differences in psychological and coping functioning between patients with IBD and IBS, and to assess the relationship of disease activity with these functions.

Methods: Seventy-four patients with IBD (mean age 43 ± 17 years, range 18–82 years) and 81 patients with IBS (mean age 37 ± 12 years, range 21–66 years) completed the questionnaires; Rosenberg Self-Esteem Scale, Toronto Alexithymia, Experiences in Close Relationships, and Sense of Coherence. Disease activity was evaluated either by the Harvey-Bradshaw index, the Simple Clinical Colitis Activity Index, or the Visual Analogue Scale for Irritable Bowel Syndrome.

Results: The study revealed that patients with IBS had higher degree of anxiety in close relationships than patients with IBD ($p = 0.003$), and lower self-esteem ($p = 0.001$). No other statistical differences between the whole groups IBS and IBD or between subgroups were seen.

Conclusions: The fact that patients with IBS seem to have higher levels of anxiety in relationships and lower self-esteem could influence the way the patient deal with the disease and how the communication with health care professionals works out. A higher awareness of the importance of past negative life events should be taken into consideration. Whether the disease or the personal traits are the primary event should be addressed in future research.

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1. Introduction

There has been a debate whether the psychological profile may play a major role in the pathogenesis of the symptoms or not in inflammatory bowel diseases (IBD), i.e. Crohn's disease (CD) and ulcerative colitis (UC), and functional gastrointestinal disorders, i.e. irritable bowel syndrome (IBS) [1]. The underlying causes of IBD and IBS, as well as the prognosis for the patients, differ. However, some similarities between the diseases are at hand. The aetiologies of IBD and IBS are still unknown, but it seems that stressors, as life events and chronic stress, as well as the individual and genetic background of the person can modulate intestinal disease activity through complex psycho-immunologic mechanisms, both on a systemic and on a gut mucosal level [2–4]. The enteric nervous system (ENS) regulates the motility, exocrine- and endocrine functions and microcirculation of the gastrointestinal tract [5]. There is a rich interconnection between ENS and the central nervous system. Therefore, sensory and secretory functions, as well as gastrointestinal motility

and perception of pain, can be affected by psychological and emotional stress directly or indirectly through this so-called brain–gut axis [6,7]. Stress is a person's response to hostile environment, and the cardiovascular, neuroendocrine, immune- and gastrointestinal systems are the first systems to experience functional deviations [2].

In patients with IBD and IBS, stress has been reported to increase the disease activity [8,9], and chronic sustained stressors are probably more important than acute stress events [10]. Changes in gastrointestinal inflammation may be mediated through changes in the hypothalamic-pituitary-adrenal axis function, alterations in bacterial-mucosal interactions, through mucosal mast cells or through mediators such as corticotropin-releasing factor [3,11]. Similar associations can be seen in patients with IBS [11], where studies have shown higher levels of psychological stress and an increased number of mast cells in patients with IBS compared to healthy volunteers [12,13]. Anxiety and depression are stress-related disorders [2], and patients with IBD and IBS correspondingly show a high frequency of both [14–16]. However, differences between the groups have been seen. Patients with CD have higher frequencies of these illnesses than patients with UC, even in disease remission [17–19]. Even constipation-predominant IBS patients seem to be more psychologically distressed than diarrhoea-predominant IBS patients [20,21]. Anxiety and depression have also

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been linked to a more severe disease manifestation in IBS [14,15,22–24], and to perception of poor quality of life [25,26].

Alexithymia, one of several personality dimensions, is characterized by difficulty to identify, perceive, and express emotions, difficulty in distinguishing between feelings and the bodily sensations of emotional arousal, lack of fantasy and an externally orientated cognitive style [27]. Alexithymia is associated with low social support and poor responses to stress [28]. This personality dimension has shown to play a role in the perception of the symptoms of IBD and IBS, but has not been shown to be influenced by the level of disease activity in patients with IBD [29]. Another study has shown that frequency of bowel movements increased with anxiety, somatization and alexithymia [16].

Patients use different coping strategies to manage difficult events, illness, and other stressors, and these can have adaptive or maladaptive effects on health status. It seems that more severe IBD disease can be linked to the use of avoidant coping strategies, characterized by the effort to escape instead of having to deal with a stressor, and poor psychological adjustment. Avoidant coping is directly related to increased self-blame, which in turn leads to poor adjustment [30], and patients with IBS have also reported higher levels of self-blame than patients with IBD [31]. There is a connection between depression and passive coping strategies for patients with IBD and IBS [32], but there are differences within these groups. Patients with CD seem to have more immature defence mechanisms [33], and maladaptive coping strategies associated with decreased quality of life compared to patients with UC [25].

Even if IBD and IBS are gastrointestinal conditions showing similar symptoms, and the signs of these conditions often overlap [34], patients with IBS have a higher level of anxiety as a personality trait [35], and have a more dysfunctional attitude compared with IBD patients [36]. Health care providers also perceive the group of patients with IBS differently when handling them in clinical practice [37]. We therefore aimed to elucidate differences in psychological and coping functioning between patients with IBD and IBS, and to assess the relationship of disease activity with these functions.

2. Materials and methods

2.1. Subjects

To be included in the study, the participants should have IBD or IBS, be older than 18 years and be able to comprehend the Swedish language well enough to answer questionnaires. The patients were all treated at the Division of Gastroenterology at the Skåne University Hospital in Malmö, Sweden. All patients were given information, oral and written, in accordance with the Declaration of Helsinki, and they had to give written informed consent before inclusion. The Ethics Committee at Lund University approved the study (2010/386).

In patients with IBD, the diagnosis was based on established criteria, i.e. findings in endoscopy, histology, laboratory parameters, and/or clinical appearance. From September to October 2010, 111 patients fulfilling the inclusion criteria were asked to participate. They were recruited either when visiting the out-care facility for a check-up, or when they were treated as in-patients at the hospital ward. The patients had the option to either complete the questionnaires at the clinic or to return them via mail in a pre-paid envelope. Patients who did not return the completed forms within three weeks of joining the study were reminded twice by phone. Patients who failed to send in the questionnaires within two weeks of receiving the second phone call were excluded from the study. Of the 111 patients that matched the inclusion criteria, 74 patients (49 with CD and 25 with UC) were finally included in the statistical analyses (Fig. 1), 40 men and 34 women ranging from 18 to 82 years of age, mean age 43.2 ± 17.0 years (Table 1).

All patients with a confirmed diagnosis of IBS according to the Rome II or III criteria [1,38,39] who had visited the Division of Gastroenterology

between January 2005 and December 2010 were invited to participate in the study. The patients were identified by searching for the ICD-10 classification of the specific codes for functional gastrointestinal disorders. A total of 417 patients were initially identified and all medical records were scrutinized. After studying the records, 265 patients remained who fulfilled the inclusion criteria. They were sent a letter with written information, informed consent and study questionnaires. Of these, 81 patients (11 men and 70 women) returned their questionnaires (Fig. 1). Mean age was 37.5 ± 12.3 years, range 21–66 years. Forty-seven of the patients had mixed IBS, 21 diarrhoea-predominated IBS and 13 constipation-predominated IBS (Table 1).

2.2. Questionnaires

The test package used in this study is a composition of applicable questionnaires; Rosenberg Self-Esteem Scale (RSES), the Toronto Alexithymia Scale (TAS-20), the Experiences in Close Relationships (ECR-36), and the Sense of Coherence (SOC-13). These four questionnaires correlate to each other, and illustrate different aspects of how a patient may relate to life. To the best of our knowledge, they have not been combined prior when comparing patients with IBD and IBS.

2.2.1. The Rosenberg Self-Esteem Scale

The RSES was developed to evaluate self-image. It is a commonly used scale when assessing global self-esteem [40], and the scale has been used world-wide [41]. It consists of 10 assertions (5 negative and 5 positive) related to overall feelings of self-worth or self-acceptance, and patients rate the level of agreement on a four-point Likert scale (1 strongly disagree to 4 strongly agree). Total scores range from 10 to 40 points, with a high score indicating a high level of self-esteem [42]. High self-esteem entails self-respect and a personal value for the individual. Contrary, having low self-esteem means that the person feels inadequate, unworthy, and has low self-respect [43]. The RSES has been shown to be a reliable and internally consistent test measurement [41,44].

2.2.2. The Toronto Alexithymia Scale

The TAS-20 is a 20-item self-report questionnaire that measures the characteristics of alexithymia. All items are rated on a five-point Likert scale, ranging from 1 to 5. The total scores range from 20 to 100 points, with a higher score indicating a higher degree of alexithymia [45]. The TAS-20 is a reliable and validated instrument used for assessing alexithymia [45–48]. The Swedish version of the TAS-20 was used [49,50].

2.2.3. The experiences in close relationships

Human beings are born with an attachment behavior that motivates them to seek proximity attachment in times of need. Attachment in adults can be measured in terms of two independent attachment-related dimensions, anxiety and avoidance [51]. Anxiety reflects the degree to which a person worries to being rejected or abandoned by their partners, or that the partner will not be available in times of need. Avoidance covers the extent to which a person distrusts the partner's good will and therefore strives to maintain independence and emotional distance, and to what degree the person is feeling comfortable with closeness and emotional intimacy [52]. The ECR has 36 statements describing the individual's typical feelings in close relationships and consists of the anxiety subscale and the avoidance subscale (18 items each). Each item is scored on a 7-point Likert scale from 1 (not at all) to 7 (very much), and higher scores indicating more anxiety and avoidance. Data on reliability and validity for the ECR in English are considerable [53]. Translation into Norwegian, back-translation into English and final correction of the Norwegian version was performed in accordance with standard procedures [54]. The Norwegian version has been validated and further translated into Swedish [55].

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