J Tokyo Wom Med Univ
80 (10・11) 305～314 (2010)

Report

Cognitive Behavioral Therapy for Patients with Inflammatory Bowel Disease: Cognitive Tendencies Concerning Recrudescence and Associated Changes

Mariko KANEKO

Department of Adult Nursing, Tokyo Women's Medical University School of Nursing

(Accepted August 25, 2010)

The purpose of this study was to conduct nursing interview sessions using cognitive behavioral therapy (CBT) on patients with inflammatory bowel disease and to discuss their cognitive tendencies concerning recrudescence and changes in cognition and behavior owing to CBT. The subjects were three people who had led a social life while suffering from inflammatory bowel disease. The method involved arranging CBT5 sessions over a two-month period. The CBT topics consisted of "concerns about recrudescence", "concerns about the future", "personal relationships", "distress over treatment options", and "anger". Of them, "concerns about recrudescence" was mentioned by every subject. Every subject had experienced the recrudescence of their symptoms after an emotionally stressful event. "'Should' thinking" and "negative thinking" were observed among cognitive tendencies toward recrudescence in patients with inflammatory bowel disease, suggesting that approaches that help them gain awareness of the significance of recrudescence and of how the mind and the body are connected may promote changes in cognition.

Key words: cognitive behavioral therapy, inflammatory bowel disease, psychiatric liaison nursing

Introduction

Inflammatory Bowel Disease (IBD) is an intractable disease and it includes Ulcerative colitis and Crohn's disease. IBD tends to develop at a young age and then relapses. The relationship between the relapses and stress has been well-proven. Regarding the psychosomatic correlation concerning IBD, Nakagawa[1] pointed out the cleanly and scrupulous characteristics of people and said that apart from whether or not they are temporarily involved in the onset of the disease, an emotional factor is involved in the process of these diseases. Masuda, Deguchi and Yamanaka[2] reported that they performed autogenic training, a cognitive approach, in the acute stages of cases of ulcerative colitis, which led to health management for five years. From these reports, it is suggested that the symptom control of IBD and the improvement of QOL (quality of life) can be obtained through health care, which deals with the psychosomatic correlation.

Meanwhile, Ohno[3] defined cognitive behavioral therapy (CBT) as "a brief psychotherapy" (psychological therapy) structured by correcting the cognitions (1), and solving problems (2) for the purpose of improving their mood state (3), based upon the concept that human moods are affected by cognition". CBT based interventions are performed so that patients can more readily adapt to a real society by alleviating stress. The method is to correct their cognition and behavior through meeting with therapists and discussing their cognitions together. Sasaki[4] suggested the possibility of the CBT approach in irritable bowel syndrome patients, describing that "it is effective in raising awareness of the cognitive state, behavior and symptoms through CBT for patients who complain about their symptoms but are not good at expressing their thinking and emotions".

When the author tried to search the MEDLINE database for the past 10 years, from 1999 to 2009 with the keywords of "IBD", "Stress management" and "CBT", no results were found concerning stud-

ies which verified the cognition state of stress targeting IBD patients or the study of stress management using CBT. It is very important to verify the cognitive state and level of stress within certain individuals who have the potential to relapse with the physical symptoms caused by stress in the field of psychiatric liaison nursing. Furthermore, it is essential to structure care for stress management in order to prevent relapses from occuring and to improve the QOL of patients. Consequently, Kaneko[5] developed "A Psychiatric Liaison Nursing Intervention for Stress Management" for IBD patients. This intervention consisted of "a relaxation method", "CBT" and "nursing consultation centering on physical and mental stress management in recuperation" over six sessions. After the intervention, the SF-36V2™ physical and mental health survey scores were increased, suggesting that any intervention promoting the awareness of the relationship between stress and physical or mental health could have positive effects on achieving a peace of mind, successful stress management and QOL[5]. Although in the abovementioned paper the variations in the stress index over time after the interventions and the characteristics of the cognitions of all targeted patients were mainly described, analyses of detailed changes in the cognitions of individuals were not mentioned. Therefore, in this paper, a study was performed focusing on the cognitive states concerning relapses of patients with IBD and changes in their cognition and behavior after CBT.

Methods

The period of study was from Aug-Dec, 2006. The subjects were recruited from those who were in the remission period of IBD, interested in stress management and agreed to participate in this study through the IBD patient's association or doctors specialized in IBD. Three subjects who had an IBD relapse as a topic of stress management were targeted for the analysis among the four subjects who were living social lives with IBD and had participated in the study of "A Psychiatric Liaison Nursing Intervention for Stress Management". In addition, those who participated in this study obtained an agreement from their attending doctors. This study was performed in the training rooms of private universities that have a nursing department and/or nursing graduate school. As a specific method, five CBT sessions were performed in two months. At the first session, information on the psychological aspects concerning cognitive therapy was presented. The contents of the information about the psychological aspects included the concept of CBT, the 10 cognitive distortions pointed out by Burns[6] along with their contents, and automatic thoughts followed by a viewpoint to study them. Cognitive therapy was explained with a pamphlet created for psycho-education based upon literature concerning cognitive therapy. After the first and the fifth sessions, they were asked to answer questions about the 10 cognitive distortions and the degrees of their cognitive types according to a Likert Scale of the four stages. At the second session, they were asked to list more than two stress scenes. The cognitions when they received stress along with their coping trends for them were discussed together with the subjects followed by a cognitive conceptual diagram by Beck[7]. After the interview, the researchers wrote down the contents of what the researchers and subjects said during the interview in a field note, and the assessments of the subjects' cognition types were performed based upon Burns' 10 kinds of cognitive distortions[6]. At the third and fourth sessions, as well as after the assessments to determine the cognitive type of the subjects and their coping methods, a cognitive technique was applied. The definition of the cognitive technique is described in the operational definition. Regarding the cognitive technique, cognitive restructuring therapy was applied to all three subjects in the process of a cognitive assessment. Then, for discussing the contents of stress and the effective methods for coping with them, when a method for controlling moods such as anxiety and anger was judged to be effective, an exposure and response prevention method was applied. Moreover, when a solution type of coping was judged to be effective, a problem-solving method was applied. The fifth session was for a summary and conclusion. In this paper, CBT sessions were conducted individually, on a

one-on-one level between a researcher and subject. The structuring of the CBT was supervised by a psychiatrist specialized in CBT, and the whole intervention was supervised by a specialist on psychiatric liaison nursing. The tasks of validating the objective evaluation for recognition and deciding which methods should be applied were assigned to the judgment of the experts of the psychiatric liaison nursing. The resolved disagreements through discussions. Intervenient participants received CBT training using the university's facilities and study groups.

Operational definition of terms

1) Cognitive patterns

The Cognitive Distortions of Burns[6] were used, of which definitions were partly reformed.

2) Cognitive restructuring therapy

The technique to restructure the new alternative cognition by identifying the cognition (automatic thoughts and images) joined to excessively negative moods, feelings and non-adaptive behaviors and investigating the cognition from various point of views[8].

3) Exposure and response prevention

One of the CBT techniques. This is a method that continues to expose subjects to a certain excessive level of their fears so that they want to take the developed escape response, which is not allowed in this simulation. Then they are exposed to their worst fears and consequently, these fears and the anxiety surrounding them are gradually reduced. This technique is performed to utilize the above mechanism[9].

4) Problem solving method

The technique to acquire the psychological mentality and skills to solve practical problems in living and working.

5) Analytical method

The subjects' cognitive tendencies by their subjective evaluation based upon the 10 cognitive distortions by Burns[6] were compared between those taken before the intervention at the first session and after the intervention at the fifth session on a scale of 1 "Not at all" to 4 "Very Much so". After that, the states of cognition of relapse were analyzed by comparing them with the cognitions about their self image, others around them and their future that were discussed in the CBT. Furthermore, the changes in cognition and behavior before and after the CBT were analyzed.

6) Ethical considerations

The subjects were informed of the purpose of this study in writing and participated in this study on their own free will. Furthermore, their freedom to withdraw from this study was guaranteed. The private data collected was protected to ensure that the individuals could not be identified from them. This method of research received approval from the Ethical Review Committee of Keio University Graduate School of Health Management.

Results

1. Attributes of subjects

There was a total of three subjects, consisting of one male and two females. One was diagnosed with Crohn's disease and the other two patients were found to have Ulcerative Colitis. The length of the period from diagnoses to the beginning of this study was from two months to 39 years, and their ages ranged from 20's to 50's.

2. Outline of CBT performed for all participants

Table 1 shows the outline of the subjects' cognitive states and changes in them between the time before the intervention at the first session, and after the intervention at the fifth session. The core beliefs in Table 1 show their definite beliefs about themselves, others and the society around them from their experiences. The topics of the CBT were anxiety concerning relapse, anxiety about the future, interpersonal relationships, trouble from the choice of therapy and anger. All of the subjects expressed anxiety about the possibility of a relapse and they had the condition of <disqualifying the positive>, and worried, "I may be hated by my significant others if the relapse occurs". Furthermore, regarding cognitive distortions, they made a <should statement> such as, "I should be fast on my feet". They also showed signs of anticipatory anxiety related to the relapse and and tended to attempt to cope with stress all by themselves. All subjects experienced a

Table 1 Outline of cognition state and modification

	Core Beliefs	Applied techniques	Cognitive distortions	Cognition Concerning Relapse		
Subjects				Concerning Self	Concerning Others	Concerning Future
A					Before Intervention	
	I don't like to be thought of badly by my family and friends I should always be fast on my feet.	Cognitive restructuring therapy	Disqualifying the positive should statement	It is my fault that the relapse occurred.	What shall I do if I cause trouble to my family?	What shall I do if the relapse occurs?
					After intervention	
				I am not to be blamed.	How others are thinking about me is how they understance me.	Even if I bother myself, the fact does not change.
B					Before Intervention	
	If I don't make an effort, I will be thought of as incompetent. I should be perfect.	Cognitive restructuring therapy Exposure and response	Should be statement Labeling and mislabeling	Relapse occurred at an important time such as during exam. If relapse occurs and I became unable to work, it will spoil my pride.	I could not meet my parents' expectations. If relapse occurs, my girlfriend may leave me.	I cannot think of marriage because of possible relapse.
					After intervention	
				The sentiment of <should statement> was reduced.	In hindsight, there were often no problems.	I will think of marriage.
C					Before Intervention	
	I should solve problems by myself.	Cognitive restructuring Problem-solving method	Should statement	I shut myself off from society because of the anxiety of relapse.	I am afraid my fiancé will not accept me if relapse occurs.	I am anxious about my job when I think of relapse.
					After intervention	
				What I can do by myself is limited.	I told my fiancé about my disease and he accepted it. I consult with others what I cannot solve by myself.	I will investigate about my job by getting information from my acquaintances.

relapse of symptoms following the event which they felt contributed to their mental stress. Cognitive restructuring therapy was applied to all subjects as a CBT technique. Additionally a problem solving method was used for the cases where the subject's core problem was job hunting because of their fear about the relapse. The exposure and response prevention method is used for cases where their anger was strong and directed towards other persons.

After the intervention at the fifth session, it was confirmed that all subjects were convinced that their relationship with their significant others would not be broken, even if a relapse occurred. It was revealed that their cognitions of their self image, as one who has a disease, others and the future, were positively changed.

3. Interview process of each case example

The following is the change in cognitions in each case example:

1) Case 1

Female, in her 50's, diagnosed with Ulcerative colitis. She had physically ill siblings, which meant she was brought up in a situation where she was always told to be patient by her parents when she had a quarrel with them. Her cognitions were that "I should be always fast on my feet" and "I should endure anything" as the stress scenes and they were classified into the <should statement>. The cognition that "It is my fault that the relapse occurred", in which she blamed herself on the problem of the relapse as it was due to her lack of health control, was classified as <Personalization>. The cognition of "The relapse of my disease causes trouble for my family" was classified as <disqualifying the positive>. At the same time, she was using coping behaviors such as "Even if my disease will relapse, I will help with housework" and "Even if I disagree with my husband, I have to be patient" as the compensation for these cognitions.

She had the experience of "What shall I do if my disease relapses?" when she could not sleep, and felt intense <anxiety>, <sadness> and <anger> as a CBT scene, which led to melena. Although she was admitted to a hospital at that time, she often forced herself to leave the hospital to do housework. When she was asked what she was afraid of the most while taking care of her health, she answered that she might be accused of being careless by her husband and that she might cause trouble for her family. Therefore, she was under the condition that she could not communicate what she was thinking because of anxiety caused by the cognition that she might be hated by her significant others if she was not "stable". In this situation, her family members thought that she could manage the housework even if her disease relapsed. Therefore, when her husband asked her to do housework, she thought, "He doesn't understand me" and asked herself " How far will he force me to work?" As a result, she felt anger, anxiety and sadness.

However, while she was receiving the CBT intervention, she was asked what she was doing for the purpose of preventing relapse. More specifically, regarding the diet and exercise for health control, she was asked to subjectively evaluate herself on how much effort she was making, presuming "0%: Not making efforts at all" and "100%: making the maximum efforts". As a result, she realized herself that she was dedicating 90 of 100% of her efforts for diet and exercise, and consequently, her cognitions changed into "I am making 90% of my effort for preventing relapse", "I don't have to be afraid of surrounding people" and "I don't feel guilty". Furthermore, her negative cognition that "because of the possibility of relapse, in order not to cause trouble for my family, I have to continuously forgo what I like to do, and therefore, I have little hope in the future" changed positively into "from now, I will live doing what I want to do". Furthermore, her behavior became, "If I am hospitalized, I will concentrate on treatment and will not leave the hospital for housework". Likewise her cognition changed to decide the order of priorities for the treatment. Her cognition for others also changed into, "How others are thinking about me is how they understand me, and they would understand me someday. Even if I bother myself with this matter, the fact does not change. "If the relapse reoccurs, I have the chance to try various things". It was reported that although

Table 2 Subjective evaluations of cognitions before intervention and after the fifth intervention

	Subjects					
	A		B		C	
	Before	After	Before	After	Before	After
Cognitive distortions						
Should statement	2	2	4	3	4	3
Disqualifying the positive	2	2	1	1	1	1
All-or-nothing thinking	3	2	4	4	1	2
Labeling and mislabeling	3	2	4	4	1	1
Overgeneralization	2	2	1	1	4	3
Emotional reasoning	1	2	3	1	2	1
Selective abstraction	3	2	1	1	1	1
Minimization	2	2	1	1	1	1
Personalization	2	1	1	1	1	1
Catastrophizing	2	2	1	1	1	3

Befor: Before Intervention, After: After intervention.

before the intervention using CBT, she vaguely perceived the stress related to relapse as "always anxious about the relapse". However, after the intervention she became aware of the vicious cycle between self-cognition and health through CBT. Moreover, during the sessions, anxiety control was performed when the signs of the relapse appeared, and it did not result with the relapse.

Owing to the facts that she was highly motivated to confront her stress about the relapse and her mental preparation was thorough, in order to find what the relapse meant to her and what she was afraid of the most, an approach was performed with the cognitive restructuring therapy so that she could be aware of the chain of events related to the body, cognition, emotion, thought and behavior. The automatic thought that "I might be hated, or accused if the relapse occurs and causes trouble for my family" changed into the cognition of "even if the relapse occurs, I am not to be blamed", and she realized that she doesn't have to blame herself or feel anxious. As a result, her cognition of stress concerning relapse favorably improved.

In the subjective evaluation of cognitions, the subject was asked about the level of how much they feel the patterns of cognitions of <all-or-nothing thinking>, <labeling and mislabeling>, <selective abstraction> and these were answered as "Generally so", but after the intervention, she answered, "A little" (Table 2).

2) Case 2

Male, in his 30's. He developed Crohn's disease when he had his heart broken. His dream in his school days was to take the same occupation as his father. However, he had a traumatic experience which made his disease relapse every time before the examination, so he had to give up his dream and could not meet his parents' expectation. He was brought up always being told what he should do during his childhood.

His stress was caused by "the irritation from traffic jams during commuting hours". He also had anger against persons to whom his own rules could not be applied. From his stress scenes that he mentioned, the cognitive tendencies that "I am incompetent, so I have to try hard, otherwise I cannot be recognized" and "I must be perfect" were classified as a <should statement> and the cognitive tendency that "a married man should support his family" was classified into <labeling and mislabeling>. Regarding the cognitions of relapse and self image, his cognition that "I am not wrong, but it is only I who has a disadvantage because the relapse occurred at the wrong time in my life" was classified into <disqualifying the positive>. He had the anxiety that "if a relapse occurred, I would be hated by my significant others" as a cognition relating to the relapse and others. Therefore, he was trying not to think about marriage with his girlfriend. Moreover, he worked without taking holidays so that he did

not have the time to think about marriage. In this way, from the viewpoint of self-care, he could not keep balance between work and rest. As a scene of stress during the CBT, when he was asked about marriage by his mother, he said "annoyance" as an automatic thought, and felt irritation, anger and anxiety, and had abdominal pain as a body sense. He found it difficult to control his moods, including the irritation from traffic jams during commuting hours and the anger toward others.

Therefore, as a CBT intervention, the exposure and response prevention method was applied in the third and fourth sessions, and behavioral therapy was applied to resolve his irritation that he felt while commuting. This was an effort to keep him in his daily life from releasing the feeling of anger on others and incorporate a way to avert his attention onto other things. As a result, his daily irritation was subdued two months after the intervention, and at the fifth session, the topics of relapse and it's coping methods were discussed. At this point, his mood was controlled. Therefore, because it was judged that he had adequate psychological preparation for the verbalization of stress events and the confrontation with the stress of relapse, cognitive restructuring therapy was applied. An approach was taken to review those things that he was possibly afraid of due to relapse and the experiences that he wanted but had to give up because of disease and the fact that he could not gain control of managing his disease. As a result, the cognition concerning relapse and self image changed from "if a relapse occurs and I become unable to work, it will spoil my pride as a man" to "my sentiment that I should ..... is receding". The cognition concerning significant others changed from "if I am admitted to a hospital, my girlfriend may leave me" to "I have often been able to keep the relationship with her when I am hospitalized". Furthermore, at the fourth session, he became aware that he felt strong anxiety about the chance of relapse, of which he had not been aware. As a result of the study, his cognitive tendencies concerning the possibility of relapse and self image along with others and the future changed from "I cannot think of marriage" to "I was very anxious about the future, but now, I think I will consider marriage".

His subjective evaluation of the <should statement> changed from "greatly so" before the intervention to "generally so" after the intervention, and his <emotional reasoning> changed from "generally so" before the intervention to "not at all" after the intervention.

3) Case 3

Female, in her 20s, diagnosed with ulcerative colitis. She was brought up in a situation where she was always told to decide everything by herself, and she was finally able to recognize the pattern of possessing the cognition of the <should statement>, "problems should be solved by oneself". She was looking for a job at that time, and in order to determine her future career, she had to solve specific problems while sufferent from relapse anxiety.

Therefore, an effective problem-solving method was applied. As a result, she realized that there were problems that cannot be solved by herself and that only if the <should statement> was modified, she did not have to handle problems by herself. Furthermore, she realized that disregarding whether or not the problem could be solved, she has to only start from the things that look manageable. Likewise, she felt relaxed with that cognition and by coping with problems in this manner.

Regarding the relationship between relapse and other persons, she told her fiancé about her disease and he accepted it. Therefore, her cognition and behavior changed so that she became able to cope with her disease, not worrying about it by herself. Regarding the relationship between relapse and the future, although she felt stress when thinking about job hunting, she said, "I will not attribute problems to my disease. Although I will not recover from my disease, I will clearly define what I can and cannot do, and will try to develop what I can do". In this manner, she modified the tendency of her cognition of self from the viewpoint of stress management, and she gained the ability to effectively cope with stress.

Her subjective evaluation of <should statement> was "greatly so" before intervention and it

changed to "generally so" after it. Those of < all-or-nothing thinking > and < labeling and mislabeling > were "greatly so" both before and after the intervention, and no change was observed. That of < emotional reasoning > was changed from "greatly so" before the intervention to "not at all" after it.

Discussion

1. The relationship between the characteristics of subjects and study concerning usefulness of stress management

As characteristics of the subjects, they repeated the relapse of their physical symptoms without psychiatric drug therapy and were living their daily lives with the stress about the possibility of a relapse. Subjects were especially highly motivated to practice stress management, so it could be considered that they were ready to learn to maintain a balance with self-care. Regarding the temporal relationship between relapse and stress, the stress events for the subjects were followed by relapses, such as melena, which was also observed during preceding studies[2)10)]. It is suggested that stress in IBD patients possibly leads to relapse.

The subjects in this study varied in age from their 20s to 50s and in their disease duration from two months to 39 years. However, anxiety over relapse was a common topic among them. Milne, Joachim and Nieshardt[11], conducted a stress management program which consisted of autogenics, personal planning skills and communication techniques targeting IBD patients. As a result, IBD patients' physical and psychosocial well-beings were improved, so they noted that the stress management techniques may have a significant therapeutic benefit for IBD patients. Furthermore, the stress management program conducted by Kaneko[5] also had a positive effect on patients' mental well-being, stress coping, and QOL after the intervention started. Also in case 1, when signs of the relapse appeared, anxiety control was performed by CBT and as a result, it did not lead to relapse. The stress management of IBD patients suggests the implication of preventive care against relapse. However, because there are very few samples, it is necessary to verify its usefulness as preventive care from the viewpoint of psychiatric liaison nursing and the effect of mental and physical integrated care on QOL.

According to a research study on 2,847 IBD patients living in Canada conducted by Hilsden, Verthoef and Best[12], approximately half of them were treated with complementary and alternative medicine (CAM), which was recognized as having positive effects on the enhancement of well-being, improvement of IBD symptoms and the stress management of sensory stress that controls disease. It was learned from the subjects of this research that there was no consultation service even though they wanted to ask about their cases. In the current medical field, human resources rarely can provide doctors who have the ability to perform psychosomatic methods on patients with the tendency to relapse and require stress management even though they do not receive psychiatric drug therapy.

CBT theory has been basically based on the premise that stressors have an influence on mode and behavior rather than how to recognize it. However, within the nursing field in Japan, stress management using CBT and the preventive care for those who have the possibility of stress relapse has not been standardized. Therefore, in the field of psychiatric liaison nursing, it is suggested to need to examine the methods to provide stress management with CBT as a form of care by focusing on the IBD patients' recognition concerning relapse.

2. Cognition state and change

The author investigated the cognition states and changes relating to relapses in IBD patients. When CBT was introduced, patients vaguely perceived the stress of relapse as "always anxious about relapse". However, they realized their self-cognition tendency through CBT, and became aware of the vicious cycle they were in and that their non-adaptive cognitions and how their emotions adversely affect their health. The common topic in this study was "anxiety of relapse". All subjects of this study had an onset of disease in their 20s. Generally speaking, IBD develops at a young age, and therefore, various anxieties including job, marriage and role conflict within their family, concerning the

relationship between their self image and other people and the tasks for the future, were observed. Specifically, regarding self image and relapse, they tended to perceive the relapse as the result of their imperfect self-management and as their fault.

Meanwhile, regarding the relationship between relapse, significant others and future, the cognition tendency that "if the relapse occurs, they may not be accepted by their significant others and society" was observed. However, at the stage where subjects became aware of their anxiety about the relationship between significant others and themselves, their non-adaptive cognition of relapse changed so that they were able to use coping behaviors, such as consulting with their significant others. Meanwhile, the subject of case 1 often left the hospital, where she was admitted, to do housework, and the subject of case 2 worked without taking holidays so that he did not have the time to think about marriage.

From the viewpoint of the self-care theory, both of them were out of balance in self-care, which is termed as <balance between activity and rest>. However, the changes of cognitions and behaviors caused by CBT led to the expansion of the self-care method.

Although the patients' degrees of relapse anxiety are evaluated from their countenance, words and actions at nursing scenes, specific care often is performed through supportive involvement with patients, such as by listening to them. When patients are in the acute phase or critical stage, this method is effective. However, for the purpose of caring for patients who have a disease where psychological stress is chronically involved in symptoms and relapse, it is important to understand the characteristics of these diseases and structure a system to provide psychosomatic approaches, for the purpose of attaining mental peace and improvement of self-care and QOL. In this study, an analysis was conducted to learn how the subjects perceived the world surrounding them in relation to relapse, by focusing on their self image, others and future in addition to coping methods. In these three case examples, the cognitive distortions such as <should statement> and <disqualifying the positive> were identified as common topics and it was suggested that investigating the meanings of relapse referring to their cognitions related to their self image, others and future individually and their non-adaptive cognitions for the purpose of changing the cognition of relapse and the way of facing the disease is an effective method.

3. Limitations of this study and future tasks

In this study, there were only three cases and the researcher served as both the intervenient and grader. Likewise, bias inevitably occured despite efforts made to prevent it through the evalutation conducted by a supervisor. Regarding the design of the study, it is necessary to further investigate the effects of intervention by verifying the effects of the experimental aspects of the design and standardizing the care method so that the intervention is always performed by several intervenients.

Presently in the medical field, although there is a need for stress management for patients without drug therapy being applied, it is undeniable that the provision of standardized care is not fully conducted. In the field of psychiatric liaison nursing, it remains a challenge to investigate and structure a nursing system including a mental support system for the process of confronting their disease. Furthermore, it also still remains difficult to design a stress management system that includes a preventive viewpoint for people who are living a social life with a relapsing disease.

Conclusion

In the three case examples of this study, during the IBD patients' cognitive state of relapse, various anxieties concerning the relationship between their self image and others and the tasks for the future, including job, marriage, and role of conflict within family were observed. The subjective cognitive distortions that were identified as common in these three case examples were <should statement>, <disqualifying the positive>, and it is suggested that the cognition concerning relapse and the way to confront disease can be changed by reconsidering the meaning of relapse concerning their self image, other persons and the future. Additionally, a CBT intervention is necessary to conduct during

the time which non-adaptive cognitions are investigated. The verification of the state of cognition concerning the relapse of IBD patients while providing them with stress management using CBT as a care for the prevention of the relapse of IBD is suggested to be a useful method.

It is suggested that structuring a stress management system for those who have the potential to relapse with stress without drug therapy provided by doctors within the field of psychiatric liaison nursing is necessary.

Acknowledgements

I appreciate everyone who extended guidance and cooperation to my project.

This study and paper is a research project of Keio University Graduate School of Health Management of 2006 in which some additions and corrections have been made.

A part of this paper was presented at the 18th Research Conference of Japan Academy of Psychiatric Mental Health Nursing.

References

1) **Nakagawa T**: Psychosomatic Medicine Learned from Clinical Cases, pp76–77, Ishiyakushuppan Kabushiki Kaisha, Tokyo (1982)
2) **Masuda A, Deguchi A, Yamanaka T**: Effect of Psychosomatic Treatment against Acute Ulcerative Colitis Exacerbation, a Case Which Received a Diagnosis of Indication for Surgery. Japanese Journal of Psychosomatic Medicine **42** (8): 521–528, 2002
3) **Ohno Y**: Recent Topics about Behavior Therapy. Japanese Journal of Molecular Psychiatry **5** (2): 123–129, 2005
4) **Sasaki D**: Cognitive Behavior Therapy against Psychosomatic Diseases of Digestive Organ System. Modern Physician **25** (12): 1531–1534, 2005
5) **Kaneko M**: A Psychiatric Liaison Nursing Intervention Method for Stress Management: Relaxation and Cognitive Behavioral Therapy in Inflammatory Bowel Disease Patients. J Jpn Academy of Nursing Science **29** (3): 76–84, 2009
6) **Burns D**: Goodbye Bad Mood. *In* FEELING GOOD, The New Mood Therapy, (Nomura S, Kakari I, Yamaoka K trans-ed). pp35, Seiwa Shoten, Tokyo (1995)
7) **Beck J**: Cognitive Therapy Practical Guidance. *In* Cognitive Therapy Basic and Beyond, (Ito E, Kamimura E, Fujisawa D trans-ed). pp419, Seiwa Shoten, Tokyo (2004)
8) **Ito E**: Cognitive Therapy: Actual Interview for Cognitive Behavior Therapy. Seiwa Shoten, Tokyo (2006)
9) **Suzuki S, Kamimura E**: Techniques of Cognitive Behavioral Therapy for Practical Persons, pp94–96, Kitaoji Shobo, Kyoto (2005)
10) **Nozue K**: Integrate Various Theories and Substantiate Them into Various Nursing Cares. Kango **50** (7): 18–26, 1989, Special extra edition
11) **Miline B, Joachim G, Niedhardt J**: A stress management programme for inflammatory bowel disease patients. Journal of Advanced Nursing **11**: 561–567, 1986
12) **Hilsden RJ, Verthoef MJ, Best A et al**: Complementary and alternative medicine use by Canadian patients with inflammatory bowel disease: results from a national survey. Am J Gastroenterol **98** (7): 1563–1568, 2003

炎症性腸疾患を抱える人々への認知行動療法
—再燃に対する認知の様相と変容—

東京女子医科大学看護学部成人看護学

金子眞理子（カネコマリコ）

本研究の目的は，炎症性腸疾患を抱える人々を対象に，認知行動療法（CBT）を用いた看護面接を適用し，炎症性腸疾患を抱える人々の再燃に対する認知の様相およびCBTによる認知・行動の変容について検討する事である．対象は炎症性腸疾患を抱え社会生活を営む者3名である．方法は，2ヵ月間にCBT5セッションを設定した．CBTのテーマは再燃の不安，将来の不安，対人関係，治療選択の悩み，怒りであった．このうち，＜再燃の不安＞は全員からきかれた．さらに，対象者全員が，精神的にストレスを感じた出来事に続いて症状が再燃した経験を有していた．炎症性腸疾患を抱える人々の再燃への認知の様相には「すべき思考」「マイナス思考」が認められ，その人にとっての再燃の意味，心身のつながり方について気づきが得られるような働きかけが認知の変容を促すことが示唆された．