

## Comparing the consequences of psychological contract breach and fulfilment changes.

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### Abstract

**A collection of chronic inflammatory illnesses of the gastrointestinal system are categorised as having inflammatory bowel disease (IBD). The prevalence and severity of Crohn's Disease (CD) and ulcerative colitis make them notable among these (UC). The development of exacerbations of varied intensity and intervals of remission during which the patient is clinically stable define the clinical course.**

**Keywords:** Psychological contract, Breach fulfillment, Well-being longitudinal.

### Introduction

The validated Spanish version of the Hospital Anxiety and Depression Scale was used to measure anxious and depressed symptoms (HADS). This item test has subscales for anxiety (7 items) and depression (7 items) that are rated in terms of severity. Each subscale has a total score that can range between 0 and 21, with a score of more than 11 indicating a clinically severe impairment [1].

The SF-36's physical functioning, role-physical, bodily pain, general health, vitality, social functioning, role-emotional, and mental health dimensions of quality of life, as well as the IBDQ's quality of life dimensions, were among the dependent variables (Bowel Symptoms, Systemic Symptoms, Functional Impairment, Social Impairment, Emotional Function, and total score).

One of the decisive elements in the decline of health-related quality of life (HRQOL) in IBD has been found as disease activity. 8 However, psychological elements can also have an impact on a patient's impression of their level of health in addition to the features directly connected to the disease itself [2].

Additionally, stress and coping mechanisms appear to be moderators of HRQOL in patients with IBD. 5,16 However, despite the fact that many studies have focused on HRQOL in IBD, very few of them have taken into account all of these psychological variables at once. As a result, it is very challenging to determine the distinct contributions of each of these variables in the various dimensions that make up HRQOL in patients with IBD [3].

The SF-36's physical functioning, role-physical, bodily pain, general health, vitality, social functioning, role-emotional, and mental health dimensions of quality of life, as well as the IBDQ's quality of life dimensions, were among the dependent

variables (Bowel Symptoms, Systemic Symptoms, Functional Impairment, Social Impairment, Emotional Function, and total score).

The sociodemographic, clinical, and psychological variables' contributions to the various SF-36 and IBDQ dimensions components associated with lower than normal values were determined using multivariate logistic regression. Using normative data from the Spanish population, the SF-36 questionnaire's scores were normalised. 31 The results were then divided into groups according to whether they fell above or below the reference population's fifth percentile. Affected dimensions were those with values that fell below the fifth percentile. We apply the previously determined cutoff value of 209 for the IBDQ. In the analysis, all relevant risk factors were taken into account as potential confounding factors. If covariables were significant, they were added to the final model [4].

However, it is also important to keep in mind that symptoms of anxiety and depression, either separately or together, contribute to explaining the perception of physical status (Physical Function, Role-Physical, Vitality), and even general health, making them important risk factors for a decline in HRQOL. As we expected, anxiety and depression constitute a risk factor for those scales related to emotional well-being (Role-Emotional and Mental Health). Given that anxiety and/or depression prevalence levels between 29%-35% have been found during remission, 13,40 as well as 80% and 60% for depression during periods of exacerbation, there is a significant prevalence of anxiety-depression comorbidity in our sample (10.5% for anxiety and 20.1% for depression). However, this prevalence is slightly lower than that previously reported. However, it must be noted that the HADS questionnaire.

A number of restrictions should be considered when interpreting the results. The cross-sectional design of our

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study is the main drawback. Only relationships between variables can be established. It is impossible to pinpoint the causal factors [5].

There are significant methodological restrictions that prevent definitive conclusions from being formed. The Rome-based study, which studied 62 UC patients, found that those with greater levels of stress had a higher probability of relapsing. This is one of the groups that has released more information concerning the link between stress and relapses. Studies conducted by the Quebec team on more than 200 IBD patients revealed a direct link between felt stress and the disease's activity.

## Conclusion

In conclusion, this study shows that HRQOL in individuals with IBD is significantly predicted by stress, anxiety, and depressive symptoms. As a result, patients who exhibit certain psychological traits may benefit from include psychological interventions that aim to change these potentially changeable aspects in their medical care. This lack of coincidence might be caused by the use of different instruments in some prior research than those that we used, which could bias how the data are interpreted. Similar to this, we can see how anxiety and depression symptoms have a significant impact on HRQOL.

In addition to how significant these factors appear to be for the wellbeing of these patients, it is also widely recognised that anxiety and depression are more closely linked to disability and functional impairment in chronic health problems than the actual disease characteristics.

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