STRESS, PSYCHOSOMATIC DISORDERS AND THANATOPHOBIA SYNDROME

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ABSTRACT

Estimates of care for Medically Unexplained Symptoms, account for between 15% and 65% of the cost of primary cares provided. Evidence-based medicine has demonstrated the link between psychological stress and psychosomatic disorders. Tanatophobia Syndrome (DCPR) or death anxiety is an absolutely natural human experience, fitting into the normality of psychological conditions. Fear of death is coexisting with fears about the disease. In the case of patients with psychosomatic disorders, tanatophobia is closely related to disease denial and non-acceptance of diagnosis. Does thanatophobia influencing the decision making in medical context of communications with psychosomatic pacients? The aim of the article is to show the liaison between somatisation and thanatophobia syndrome, in bio-psiho-social approach of patient. This substudy is part of a larger work, a prospective, mixed study, carried out in 2008-2016, including 200 subjects belong to the two categories assigned to its design. We used as clinimetric tools, three psychological questionnaires. In the analysis of each of the branches, we structured syndromes according with the DCPR (Diagnostic Criteria for Psychosomatic Research). The results of the present study reveal that tanatophobia syndrome is present in the largest proportion of the psychosomatically affected patients profile as they age and they have a number of peculiarities. Acceptance of diagnosis and choice of therapy is influenced by personal, social and environmental factors, and it must be essential to integrating and analyzing data in a biopsychosocial context.

Keywords: Thanatophobia; Psychosomatic Patient; Medical Communications; Somatisation;

INTRODUCTION

Classical medicine draws a clear line of delimitation between somatic and psychological pathology. The concept underlying this type of approach is based on somatic / psychic dualism, the human being made up of two distinct parts. However, the current trend is to draw a clear line between psychiatric and psychosomatic disorders, which are now increasingly attributed to internal medicine (Zipfel S., Herzog W., Kruse J., Jenningsen P., 2016). Modern medicine uses new concepts in diagnostic and therapeutic approach, recognizing that the health care structures are confronted with the variability and multidimensionality due to decipherment of complex human-world / medium interaction mechanisms at all levels, from micro to macro, from cell to socio-cultural. Currently, psychosomatic research tries to find arguments in favor of a bio-psycho-social approach using biomedical models, leading to specific quantifiable mechanisms that reveal a causal chain of events (Smith & Dwamena, 2007).

1. PROBLEM STATEMENT

Despite the many controversies resulting from the use of psychosomatic terminology, psychosomatic medicine can be defined as a comprehensive interdisciplinary field that assesses psychosocial factors that influence individual vulnerability and can trigger any kind of disease (Conley &Bishop, 2016). In other words, it is about holistic patient care in patient - centered therapy and is a way of integrating psychological therapies into prevention, treatment and recovery in medicine (Fava & Freyberger, 1998).

Psychosomatics medicine places the individual in the center of its concerns, and addresses the contextual influences on health in an integrated manner according to the biopsychosocial model. In other terms, we can conclude that current medicine has become an integrated science where the main directions of interest are represented by the ethical approach to the concept of illness, the establishment of an optimal therapeutic relationship, the application of evidence-based medicine's principles in medical practice and the individualization of treatment and last but not least the increase in the quality of life. For this reason, in the sense of psychosomatics medicine, health is the only status that integrates into an ideal form the psyche and the somatic (Alexander F, 1950).

Somatic pathology appears as an effect of disrupting this steady state. Considered as a heterogeneous domain, psychosomatic medicine, the mind-body domain, includes "classical" psychosomatic disorders, but also sporadic episodes in which the body has an inappropriately answer to the action of psychic aggression factors. Currently (Levenson L, 2007), clinical and theoretical medical research, based on the biopsychosocial model, proves that psychosocial factors can be causes, co-factors or sequelae of many diseases. Regarding the nature of stressors, they may be psychological factors or other factors among which we can include genetic factors or life experiences that can alter the stress response system (Porcelli &De Carne, 2014). The benefits of the psychosomatic approach have also been recognized in palliative medicine. In this context, the notion of salutogenesis is increasingly used. According to Antonovsky's theoretical model, salutogenesis is "the ensemble of personal resources, psychological and cultural factors, mentality, values and beliefs that give us resistance and support us in successfully confronting with stress" (Antonovsky A., 1979).

What determinant factor that triggers the individual’s attitude (defensive or offensive) in the patient’s role? The core of any patient's behavior is the fear of suffering (pain) that conceals the fear of death.

2. RESEARCH QUESTIONS

The objective of this study was to identify the obstacles that interposed between patient and physician in terms of diagnostic and therapeutic acceptance in psychosomatic diseases based on the therapeutic relationship. The research questions of this sub-study were as follows:

- What social variables could contribute to this?
- What is the role of anxiety triggered by the prospect of death in the health care economy?

3. PURPOSE OF THE STUDY

The hypothesis of the present thesis is to demonstrate that there is a direct causal link between the therapeutic relationship and the acceptance of diagnosis and, implicitly, of the specific therapy for psychosomatic disorders. Beyond the theoretical part, this paper refers to the practical implications for the role of "patient", assumed consciously, starting from the therapeutic relationship, considered the central element of the medical act in all its complexity. In this sense, the patient actively contributes to his / her own healing, to the

prevention activity, to the evaluation of the therapy beyond the reductionism / limits imposed by the pharmacological treatment (Dawson D, Moghaddam N, 2015) and at the understanding of the psychosocial context of the psychosomatic diseases (Kallivalayl RA& Varghese PP,2010). Its purpose is not limited to basic research, its extension being represented by a diagnostic algorithm of patients with psychosomatic disease, which has utility in clinical practice.

The motivation of the chosen approach was that psychosomatic disorders are often undiagnosed, the mechanism being the patient's refusal to accept the diagnosis (Schumacher S & Rief W, 2013). In most situations, this creates a number of problems in the therapeutic relationship, in the sense of deterioration up to destruction. One reason for not accepting the diagnosis is stigmatizing the patient with psychological problems / mental illness (Fava & Porcelli, 2010).

Therefore, there is a need for a new type of approach that emphasizes that the psychosomatic does not identify with border psychiatry, it can not be limited to it, but can target any other field of medicine. The general approach to psychosomatic medicine field has led to a number of sub-disciplines in its fields of application: psychology, psycho-psychology, psycho-neuroendocrinology, psycho - immunology, psycho - dermatology. The current study is in the category of those whose results can be used in clinical health services, addressing a specific phenomenon and how to apply it, through testing hypotheses and providing explanations.

4. RESEARCH METHODS

1. Research Design

The study has been achieved in the period 2008-2016, being included in the prospective and mixed studie's category. Design in the form of a mixed study model was based on the need to meet both quantitative and qualitative criteria (phenomenological feature). Qualitative research has provided an opportunity to decipher how patients perceive the health and illness experience as well as the interaction between the "actors" involved in the therapeutic relationship.

The collected data was processed using a GRETL software (statistical analysis software) combined with a quantitative one developed by the author in both Microsoft Excel (we programmed the information in the questionnaire using the functions available in the program) as well as in GRETL. The target group consisted of 100 adult patients with psychosomatic disorders, the control group comprised for the validity of the study an equal number of patients without psychosomatic disorders. In the sample of patients with psychosomatic disorders, we structured three sub-profiles to better quantify the degree of psychosomatic affecting: demoralized-worried, demoralized - disappointed and demoralized-desperately. We used three questionnaires (Scale of Attitude to Disease, Determinants of Patient Satisfaction in Relationship with Doctor, GPAQ- General Practice Assessment Questionnaire).

The chosen questions have been opened to encourage patients to give honest, spontaneous answers. The realization of this study required a participatory collaboration from the author, being in this context a participant in the study (investigator and executor of the medical act), but also an observer. Due to the peculiarity of the research theme, the qualitative component prevailed in the study, determined mainly by the research question. Patients were informed of all aspects of the study, thus meeting the ethical and legal criteria for studies on human subjects.

2. Research Construct

According to the principles of the qualitative approach, we emphasized the subjectives experiences experienced by people, generating data about inter-human relationships in different social contexts. Through this study, I tried to generate depth information, difficult to quantify, such as meanings, understandings and experiences. The argument in favor of qualitative research in the case of the study of relational phenomena and the implications arising from this type of relationship was that only "the researcher who uses the qualitative method is the instrument sufficiently complex to understand and draw conclusions about human existence and the rules which governs relations between individuals "(Lave & Kvale, 1995). The DCPR (Fava et al. 1995), is structured as a set of 12 psychosomatic syndromes used since 1995 as operational tools with prognostic and therapeutic implications. It has been used as a diagnostic and conceptual framework, in the study. We reported the study to the last two editions of the DSM (initially at DSM-IV, since the start date of this paper was prior to DSM-V's entry into force) (Demazeux & Singy, 2015).

5.FINDINGS

The results of the study have shown the implication of some social factors such as news and the existence of practices (obituaries etc) in triggering tanatophobia. In addition, the increase of biological age is incriminated in tanatophobia's growth. In addition, the global analysis of the study confirmed that adherence to a range of risk behaviors (healthy eating and smoking) is related to tanatophobia and psychosomatic illness.

CONCLUSION

Tanatophobia Syndrome is based on three items, according to DCPR:

S13. Are you scared of news that reminds you of the existence of death (funeral, obituaries)?

S14.The death's idea scares you?

S15. Does scare you the thought that you might soon die?

The statistical processing of the responses received from the respondents belonging to the studied group led to the following conclusions:

1.Fear of death is present in a higher proportion in patients with psychosomatic disease, as compared to the control group of psychosomatically unaffected patients, for all three items.

2. Tanatophobia syndrome occurs with the highest frequency in relation to the significance of death per se (item S14).

3. Regarding the general average or the deviation of the psychosomatically affected behavior to the psychosomatic unaffected behavior, we found that the greatest deviation from the general behavior is found in the case of item S13, item a whose significance refers to the social component of the phenomenon tanatophobia (news, obituaries).

Regarding the analysis of the distribution of the tatophobia syndrome among the psychosomatically affected patients with reference to the salutogenesis correlation, we found that there is a concordance of the salutogenetic behavior in relation to the two analyzed elements (avoidance of unhealthy food and smoking's behavior, which are considered risk behaviors) to the general profile and the psychosomatic affected profile. Although psychosomatic disease does not alter salutogenesis of general's profile, compliance at salutogenic behavior decreases as compared to the profile of patients without psychosomatic

disorders. Regarding the comparison of the two behavior, we noticed that salutogenesis adherence is higher at smoking than in unhealthy food, in other words, patients consider smoking more harmful than eating unhealthy foods. This finding is valid for all three profiles analyzed: general (whole sample), profile with psychosomatic disorders and profile without psychosomatic disease.

Analysis of the S15 item on the general profile and the three sub-profiles mentioned led to the conclusion that the tanatophobia, characteristic of the psychosomatic disorders, does not reach the maximum odds in this context, namely that there is no direct relation of the proportionality between the level of psychosomatic afectation and the fear of death.

6. Regarding the frequency of tanatophobia in the general population, we noticed an increase with aging.

BIBLIOGRAPHY:

[1] Alexander F. (1950) Psychosomatic medicine. New York: Norton, 132-209;
[2] Antonovsky A. (1979) "Health, Stress and Coping"; San Francisco, Jossey-Bass Publishers, 50-250;
[3] Curis C., Psychosomatic Disease in Internal Medicine – Diagnostic and Therapeutic Acceptance, Doctoral Thesis, 2017 Jul 31;
[4] Demazeux S., Singy P.(2015), The DSM-5 in Perspective, Philosophical Reflections on the Psychiatric Babel, Springer Science + Business Media Dordrecht, ISBN 978-94-017-9765-8 (eBook);
[5] Fava G. A., Freyberger H (1998), Handbook of Psychosomatic Medicine, International Universities Press, ISBN 0823623025,126-426, 578- 641;
[6] Conley CC, Bishop BT,&Andersen BL(2016), Emotions and Emotion Regulation in Breast Cancer Survivorship, Healthcare (Basel),10;4(3).
[7] Dawson D, Moghaddam N (2015) Formulation in Action: Applying Psychological Theory to Clinical Practice, de Gruyter Open Ltd, Warsaw/Berlin, ISBN: 978-3-11047099-4;62-74; 79-91;
[8] Fava G. A., Porcelli P.& Rafanelli C. et al (2010), Journal of Clinic Psychiatry, The spectrum of anxiety disorders in the medically ill; 71(7):910-4;
[9] Kallivalayl RA, Varghese PP(2010), Understanding and managing somatoform disorders: Making sense of non-sense, Indian Journal of Psychiatry, 52(Suppli1): S249-S245;
[10] Lave J, Kvale S, (1995) What is Anthropological Research? International Journal of Qualitative Studies in Education 8(3), 219-228;
[11] Levenson J. L.(2007), Essentials of psychosomatic Medicine, American Psychiatric Pub, ISBN-13: 978-1585622467 128-156, 257-368, 456-547;
[12] Porcelli P., De Carne M.& Leandro G.(2014), Alexithymia and gastrointestinal specific-anxiety in moderate to severe irritable bowel syndrome, Comprehensive Psychiatry, 55(7) 1647-1653;
[13] Smith R.C., Dwamena C.F.(2007), Classification and diagnosis of patient with medically unexplained symptoms, Journal of general Internal Medicine, 22(5):685-691;
[14] Schumacher S, Rief W& Brahler E. et al (2013), Disagreement in doctor's and patient's rating about medically unexplained symptoms and health care use, Int J Behav Med; 20(1):30-7;
[15] Zipfel S, Herzog W& Kruse J. et al.(2016). Psychosomatic medicine in Germany: more timely than ever, Psychotherapy and Psychosomatics, Vol.85(5), 262-269;