



Struggling in an emotional avoidance culture: A qualitative study of stress as a predisposing factor for somatoform disorders



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ABSTRACT

Objective: To explore patterns of experienced stress and stress reactions before the onset of illness in the life history of patients with severe somatoform disorders to identify predisposing stress-mechanisms.

Methods: A systematic, thematic analysis was conducted on data collected from 24 semi-structured individual life history interviews.

Results: Generally, patients had experienced high psychosocial stress during childhood/youth. However, there was considerable variability. Characteristic of all patients were narrations of how communication with significant adults about problems, concerns, and emotions related to stress were experienced to be difficult. The patients described how this involved conflicts stemming from perceived absent, insufficient, or dismissive communication during interactions with significant adults. We conceptualized this empirically based core theme as “emotional avoidance culture.” Further, three related subthemes were identified: Generally, patients 1.) experienced difficulties communicating problems, concerns, and related complex feelings in close social relations; 2.) adapted their emotional reactions and communication to an emotional avoidance culture, suppressing their needs, vulnerability and feelings of sadness and anger that were not recognized by significant adults; and 3.) disconnected their stress reaction awareness from stressful bodily sensations by using avoidant behaviors e.g. by being highly active.

Conclusion: Patients adapted to an emotional avoidance culture characterized by difficult and conflicting communication of concerns and related emotions in social interactions with significant adults. Patients experienced low ability to identify and express stress-related cognitions, emotions and feelings, and low bodily and emotional self-contact, which made them vulnerable to stressors. Generally, patients resolved stress by avoidant behaviors, prolonging their stress experience.

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Introduction

Diseases that are associated with psychosomatic symptoms, like somatoform disorders (SD) and fibromyalgia (FM), are contested diseases with overlapping symptoms and uncertain etiology [1,2]. Evidence indicates that stress is part of the psychopathology, but the exact mechanisms between experienced stress and reactions to stress and the development of these psychosomatic diseases remain uncertain [1–7]. Perceived stress is defined as “psychological stress is a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being” [8]. Whether the stressor is perceived as a challenge or a threat will depend on former life experiences, stress appraisal, and coping resources [8–11]. Thus, memories, emotions, and coping resources play a crucial role in the stress experience and

response [12,13]. The stress-concept is perceived as a bio-psychosocial phenomenon involving a subjective experience, a social context, and a physiological response.

The following familial risk factors in childhood have been identified associated with SD: somatization or organic disease of parents, psychopathology in close family members, dysfunctional family climate, traumatic experiences, and insecure attachment [14]. Another study finds an association between fibromyalgia and physical and sexual abuse [15]. Patients with fibromyalgia and/or SD more frequently report a poor emotional relationship with both parents, a lack of physical affection, and physical quarrels between parents [16]. Research examining the nature of these patients' early family environments also finds a significant association between: family dysfunction [17], trauma history, emotional abuse and neglect [18,19], insecure attachment styles [14,19–21] deriving from a dysfunctional milieu [22], negative affectivity [23,24], and alexithymia [23,25–28]. Especially difficulty identifying feelings are associated with higher levels of psychological distress [27]. Affect dysregulation [29–31], deficits in affective theory of mind [32], suppression of affect [30,31,33], and decreased body and emotional awareness [34,35] are found associated with SD. Neuroendocrine

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dysfunctions are also found associated with fibromyalgia [36] and childhood trauma history [37]. Abnormal neural stress-processing is identified in relation to SD [33,38] suggesting some types of emotional and cognitive neglect.

Studies demonstrate that suffering from a contested psychosomatic illness can be stressful, related to identity crisis, and stigmatizing processes [39–47]. These patients long for existential recognition of their illness [41–47], needs, feelings, and vulnerability [48], and they experience insecure illness perceptions [41–45] and difficulties communicating emotions of distress, which often leads to avoidant coping [48]. The aim of this paper is to gain new in-depth knowledge on the complex interaction of how patients experienced stress, reacted to and coped with stress *before* the onset of illness, which has not previously been investigated with qualitative methods, in order to identify new hypothesis on how stress can be a risk factor for developing psychosomatic related diseases. This study has explored all aspects that turned up to be significant in the patients' life narratives related to the research-target supplemented by questions echoing findings in the literature: What early experiences did these patients encounter, and how was the atmosphere in their childhood environments? What kinds of stressors, meaning traumatic events or difficult circumstances, had they experienced before falling ill? How did they react emotionally, somatically, and behaviorally to these stressors, and how did they cope to gain relief? How did they experience their interpersonal interactions and attachments to significant others including parents, teachers, friends and intimate partners? How did they talk about stressful experiences and related emotions of distress in social interactions, and what were their experiences of being socially supported?

Method

Study design and data sampling

This study employed a cross-sectional, retrospective design using semi-structured, individual life history interviews with 24 patients. Data was based on a purposeful sample collected among referred patients newly diagnosed with severe SD, recruited from "The Research Clinic for Functional Disorders and Psychosomatics", Aarhus University Hospital, Denmark. Inclusion-criteria: Newly diagnosed with severe multi organ SD/bodily distress syndrome [1], moderate to severe impairment for at least 6 months, 20–50 years, and in case of co-morbid mental disorders e.g. depression/anxiety or co-morbid medical condition e.g. asthma/diabetes it should be clearly differentiated from the SD symptoms. Exclusion-criteria: Current alcohol or drug abuse, pregnancy and not fluent in the Danish language. Twenty-four patients were purposefully sampled obtaining demographic variations in age, employment status and location [49] and reaching saturation. Saturation is the point in data collection, when no new information emerged in relation to the target phenomenon [49].

Interviews lasted 2 to 4 h covering diverse aspects related to the patients' life-experiences of stress, reactions to stress, and coping behaviors addressing external and internal stressful conditions as well as the psychosocial context. Stress experiences were explained to the patients to be experiences appraised by the patient as taxing or exceeding their resources and endangering their well-being. The questions explored any elements in the patient's life history that the patient retrospectively described as related to feelings or bodily symptoms of distress, the meaning the experiences had, and how they influenced the patient's self-image and social identity. Most questions explored the spontaneous narrations related to the topic that the patient offered. Questions were raised in as open a manner as possible to make space for the patients' voiced narratives, and were supplemented with questions echoing the literature (see topics explored, Table 1). Twenty-one of the interviews took place in the patients' homes and three at "The Research Clinic". Interviews were carried out by ABL and supervised by a senior researcher. The researcher observed significant nonverbal signs as clues for further

Table 1

Examples of topics explored during interview.

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| How stressful events and circumstances were experienced and influenced self-image and social identity in childhood/youth/early adulthood, and how the patient had reacted to these stress-related memories were explored in relation to: |
| The environment at home in childhood/youth |
| Attachment with significant adults like parents and other care takers |
| Communication with significant adults of stressful events and related needs and feelings |
| Experience of social support related to stressful events and conditions |
| Relation to siblings |
| Atmosphere in the family |
| The environment in school in childhood/youth |
| Relation to classmates and teachers |
| Experienced academic performance |
| Experienced role in the social hierarchy |
| Atmosphere in school |
| Communication of stressful events with classmates and teachers |
| Related to leisure time environment |
| Stress relieving circumstances |
| Atmosphere and communication |
| Stressful experiences related to education in youth/early adulthood |
| Motivation behind significant choices |
| Academic performance |
| Relation to study mates |
| Stressful experiences related to work |
| Working attachment and identity |
| Relation to colleagues |
| Relation to superiors |
| Social relations in adulthood |
| Communication and attachment to intimate partners |
| Relation to close social relations |
| Relation to children (as a parent themselves) |
| Reactions related to stressful events and circumstances |
| Bodily reactions |
| Emotional reactions |
| Cognitive reactions |
| Behavioral reactions |
| Interrelated social interactions |

questioning especially related to traumatic/emotional content: fisted hands, tense muscles or raised shoulders implying fight/flight postures, and breath holding or bodily stiffness revealing freezing postures that were sometimes followed by tearful eyes, laughing, or a deep sigh as signs of relief. The interviews were recorded digitally and subsequently transcribed verbatim.

Epistemology and thematic analysis

Qualitative life history research can be epistemologically described as "defining the growth of a person in a cultural milieu and to make theoretical sense of it" [50]. Life history research is a valid research method for identifying thematic patterns [51–53]. The analysis was based on a thematic methodology identifying central themes influencing the patients' individual stress experiences/reactions as well as the contextual social processes. The analysis was performed consistently following the six phases according to thematic analytic procedures: Becoming familiar with data involving transcription and reflective reading, generating initial codes, searching for themes, reviewing and refining themes for coherent patterns, defining and naming themes and producing the report [54]. The coding was done (using NVivo 8) by the first author ABL systematically supervised by the senior researchers. Thus the coding of the central transcripts was elaborated and discussed within the research-group to ensure reliability and to achieve consensus on the essential codes and the conceptualization of the findings. Hypotheses, concepts, core theme and related sub-themes were all similarly developed in the research group. The core-concept and interrelated categories were identified and tested with axial/selective coding-procedures. Comparisons were constantly made between codes, concepts, and themes. The study was carried out in accordance with the Declaration of Helsinki, and presented to the local Ethics Committee, who decided

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