Comparison of functional dyspepsia with organic dyspepsia in terms of attachment patterns

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Abstract

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Aim: Functional dyspepsia, originates from gastroduodenal region, is described as resistant and recurring dyspeptic symptoms with unknown etiology. Although there is some evidence in support of a relationship between functional dyspepsia and psychopathology, attachment patterns of functional dyspepsia patients have not been studied yet. In our study, we aimed to compare attachment patterns of functional dyspepsia patients with organic dyspepsia patients and healthy volunteers.

Method: 43 patients diagnosed with functional dyspepsia, 38 patients with organic dyspepsia and 42 healthy volunteers matched in terms of age, sex and education were included in the study. All participants were evaluated using a socio-demographic and clinical data questionnaire, the State and Trait Anxiety Inventory, the Experiences in Close Relationships Questionnaire and the Adult Attachment Scale.

Results: There was no difference in sociodemographic features among the three groups. Functional dyspepsia group exhibited significantly higher Trait Anxiety scores compared to organic dyspepsia and control groups. Control group showed significantly higher secure attachment styles compared to functional dyspepsia and organic dyspepsia groups, there was no difference between groups in non-secure attachment styles according to triple attachment model. Dimensionally, functional dyspepsia group showed more avoidant attachment patterns than organic dyspepsia groups and organic dyspepsia group showed more avoidant attachment patterns than control group.

Conclusion: According to our findings, Functional dyspepsia patients are more anxious than organic dyspepsia patients and healthy volunteers. Non-secure attachment patterns were seen generally in all dyspeptic patients while avoidant attachment patterns are more prominent in functional dyspepsia patients.

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1. Introduction

Although functional dyspepsia (FD) is the most common functional gastrointestinal disorder (FGID) its etiopathogenesis has not been fully clarified. The prevalence rates of functional dyspepsia are reported about 20–30% in western countries [1] and similarly it is estimated 30% in Turkey [2]. The Rome III committee defined functional dyspepsia as the presence of symptoms thought to originate in the gastroduodenal region without any organic, systemic, or metabolic diseases [3] and these symptoms are bothersome epigastric pain, epigastric burning, early satiation, postprandial fullness [4]. In contrast to functional dyspepsia organic dyspepsia is the diagnosis in cases of definite organic pathology can be determined in patients presenting with dyspeptic symptoms [5].

Functional dyspepsia (FD) has been described as a multifactorial disease that involves the enteric nervous system (ENS), afferent sensory neurons, and the central nervous system (CNS). Complex interactions and emotional variables have been shown to contribute to the manifestation of FD symptoms. The emotional stress, in particular, has been documented as an important factor in the pathogenesis of FD [6,7]. After exposure to stress, a complete activation of hypothalamopituitary-adrenal axis (HPA) and autonomic nervous system (ANS) associated with secretion of the corticotrophin releasing hormone (CRH) lead to physical and psychological symptoms [6]. One of the symptoms that occur after this stress-related activation is associated with the gastrointestinal system [6]. Studies conducted in functional dyspepsia (FD) patients demonstrated a higher prevalence of anxiety and depression symptoms, neurotic personality characteristics, somatic complaints, sexual and physical abuse history [8–10].

One of the important factor that determine emotional and neuroendocrine responses to stress is the attachment system that is thought to

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had developed at a very early age and is a determinant of wellbeing in the later stages of life [11]. Attachment theory investigates emotional bonds based on the first relationship that the infant had established with caregiver through instinctual proximity seeking behavior and has been recognized as a development theory with the most scientific evidence [12]. According to attachment theory attachment styles show secure or insecure characteristics and classified categorically in three different attachment patterns as secure, anxious-ambivalent and anxious-avoidant or in four different attachment patterns as secure, preoccupied, fearful and dismissing [13]. Mikulincer and Shaver claimed that attachment patterns can be evaluated dimensionally as well as categorically and dimensional approach could diminish some limitations of categorical approach [14]. According to this model every person uses attachment styles in two dimensions as avoidance and anxiety. Avoidance dimension reflects a deactivation strategy and anxiety dimension reflects hyperactivation strategy. While insecure attachment styles have been considered to be predictors of psychopathology later in life, the secure attachments have been associated with a healthy process [15]. Various studies showed the association between insecure attachment styles and psychiatric disorders such as panic disorder, social phobia, posttraumatic stress disorder, obsessive-compulsive disorder, dissociative disorders, eating disorders, substance abuse disorders [16–20].

As mentioned above, attachment is one of the determinants of neuroendocrine response to stress [11]. Studies in both humans and animals showed that negative early life events change the HPA axis function and lead to dysfunction [21,22]. In addition, studies also showed that insecure attachment styles can contribute to HPA axis dysfunction [23,24]. Infant studies about stress reactivity have showed that securely attached infants do not have elevated cortisol levels with stress but infants with the insecure attachment styles have elevated cortisol levels [25] and greater hormonal response to stressful situations [26]. Attachment insecurity affects physical health throughout the lifespan [27]. Neuroendocrine response associated with attachment together with Psychological factors creates somatic symptoms such as pain and help seeking behaviors.

The insecure attachment in non-clinical population has been closely associated hyper-vigilance towards pain [28], increased fear of pain [28], low pain threshold [29], and insufficient ability to cope [30]. In patients with chronic pain, the attachment has been closely correlated with the assessment of pain. In addition, those with insecure attachment have been shown to have a lower pain detection threshold [31], poor ability to cope with pain and frequently visit health care centers [18]. Thus, individuals that show insecure attachment have been shown to be prone to develop pain, experience more intense pain, and have more inhibited lives [18,29].

Although there are no studies in the literature that evaluated attachment properties in patients with FD, Attachment styles could be important in understanding the etiology of FD. Insecure attachment and avoidance dimension was detected at high rates in studies with patients that had fibromyalgia, which is phenomenologically similar to FD, and had widespread pain without any detected structural pathology [32]. On the other hand, a study that investigated the relationship between parental attitudes, somatization, and abuse in patients diagnosed with irritable bowel syndrome, which is a functional gastrointestinal disorder (FGID) and seen as often as FD found that the parents’ negative attitude-behavior which is associated with attachment was highly related with somatization [33]. Also, studies have reported higher rates of insecure attachment styles in patients suffering from gastroesophageal reflux disease which is one of the organic causes of dyspepsia [34].

In this context; FD patients are more closely linked with emotional stress and stress is known as an important etiological factor for gastrointestinal system diseases [27,35]. Although FD etiopathogenesis has not been fully clarified there is a strong relationship between FD and stress. Regarding stress management, secure attachment patterns are reported to be important in the neuroendocrine response to stress. In light of the above mentioned our first hypothesis was FD group would have higher trait anxiety and history of outpatient psychiatric treatment compared to patients with organic dyspepsia (OD) and/or healthy controls because of deficiency in stress management. Depending on these our main hypothesis was that insecure attachment and dimensionally avoidance would be more prevalent in patients with FD compared to patients with organic dyspepsia (OD) and/or healthy controls. The purpose of the present study was to compare the attachment styles of functional dyspepsia patients with organic dyspepsia patients and healthy controls.

2. Material and methods

2.1. Selection and formation of groups

The study group comprised 45 consecutive patients admitted to the Bakırköy Dr. Sadi Konuk Training and Research Hospital gastroenterology clinic with dyspeptic complaints, whose gastroenterology evaluation met the criteria for inclusion described below, and who were diagnosed with functional dyspepsia based on the Rome III diagnostic criteria. In addition, the study included 45 consecutive organic dyspepsia (OD) patients with similar symptoms and conditions that were diagnosed with diseases such as ulcer, erosive gastritis, gastric ulcer, and gastro-esophageal reflux. Among these cases, 7 were from the OD group (2 patients with severe physiological stress due to acute gastrointestinal symptoms, 2 patients whose forms were incomplete, 2 patients that who gave conflicting information, and 1 patient whose psychiatric diagnosis was made subsequently) and 2 cases from the FD group (1 patient whose forms were incomplete and 1 patient who gave conflicting information) were excluded from the study.

After complete description of the study to all subjects, written informed consent was obtained. The Control group consisted of 42 healthy volunteers in similar sociodemographic characteristics with patient group and were asked to fill out the questionnaires applied to study group. The study was approved by the ethics committee of the Bakırköy Research and Training Hospital for Psychiatry, Neurology and Neurosurgery (04.02.2014/376). 43 patients in FD group, 38 patients in OD group and 42 healthy controls completed the study.

2.2. Inclusion and exclusion criteria

Participants aged between 16 and 65 years who had at least 5 years of education (elementary school) were enrolled. Patients were included in the OD group if they were diagnosed with organic dyspepsia and included in the FD group if they were diagnosed with functional dyspepsia (FD) by their assessing gastroenterologist according to Roma III criteria. Inclusion criteria for healthy controls (HC) were the absence of any current psychiatric or gastrointestinal disorder.

Exclusion criteria were clinically detected mental retardation, deficit in visual or auditory functions that affect communication severely, presence of electro-convulsive therapy in recent history, presence of any history of head trauma or central nervous system pathology with loss of consciousness or cognitive disorder, assessment of a psychiatric disorder with SCID-I evaluation, organic conditions that cause severe psychological stress (e.g. cardiac failure, renal failure, etc.), having a history of psychotic disorders.

2.3. Instruments

Sociodemographic and Clinical Data Form: This is an interview form developed by the researchers according to the aim of the research to assess sociodemographic characteristics, psychiatric history and clinical features of the patients.

SCID-I Structured Clinical Interview for Axis I Disorder: (SCID-I) is a diagnostic questionnaire developed by First et al. in 1997 and published by the American Psychiatric Association, used to determine DSM-IV Axis
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