AMOGHVARTA

ISSN : 2583-3189

Comparison of Some Psychological Traits between Psychosomatics and Normal

ORIGINAL ARTICLE

Author
Dr. Sujit Kumar
M.A. (Psychology), Ph.D
At + Post : Dhangawan
Dist: Jehanabad, Bihar, INDIA

Abstract

The present study intended to compare psychosomatics and normal in terms of stress, anxiety and depression. It was hypothesized that psychosomatics and normal respondents would differ significantly from one another in terms of (i) stress, (ii) anxiety and (iii) depression. For the purpose psychosomatics (peptic ulcer : 50, bronchial asthma : 50; diabetes : 50) and normal (N = 50 for each group) were administered stress scale, anxiety scale and depression inventory and obtained data were treated using t-test. Obtained t-values were found significant. Thus, hypotheses were retained. It was found that each group of psychosomatic patients excelled over their counterpart normal respondents in terms of higher level of stress, high anxiety and high depression. Thus, it was concluded that psychosomatic groups of patients experience comparatively high level of stress, high anxiety and high depression respectively.

Key Words

Psychological Traits, Stress, Anxiety, Depression.

Introduction

Psychosomatics refers to the interrelation between the mind and the body, where emotional or psychological factors contribute to the manifestation of physical symptoms, even though no apparent physiological cause can be found. This concept is deeply rooted in the understanding that psychological distress can have a tangible effect on bodily functions, often leading to illnesses or disorders that are linked to emotional or mental disturbances. A person with psychosomatic issues may experience physical ailments such as chronic pain, gastrointestinal problems, or headaches that cannot be entirely explained by medical tests, suggesting that emotional conflicts or mental stress are at play.

In contrast, "normal" psychological functioning typically refers to individuals whose mental and emotional states are well-regulated, leading to healthy physical functioning. Such individuals can handle everyday stressors and emotional challenges without letting them manifest in chronic physical symptoms. While everyone may experience emotional stress or occasional psychological discomfort, those with normal psychological functioning are usually able to process and cope with these feelings in a way that does not result in severe or ongoing physical manifestations.

The comparison between psychosomatic and normal psychological traits often revolves around how the mind influences the body and the individual's ability to regulate emotions, cope with stress, and manage their mental health. Understanding these comparisons can help clarify why some individuals develop psychosomatic disorders while others do not. It can also provide insight into treatment strategies for both conditions, which may involve psychological therapy, stress management techniques, and, in some cases, medical interventions.

A key psychological trait that differentiates individuals with psychosomatic disorders from those with normal psychological functioning is the capacity for emotional regulation. People who experience psychosomatic symptoms often struggle with regulating their emotions, particularly when faced with stress or emotional trauma. They may internalize negative feelings such as anger, anxiety, or sadness, which can eventually manifest as physical symptoms. For example, an individual under prolonged emotional distress may develop chronic headaches, stomach ulcers, or muscle pain due to unresolved emotional issues.

In contrast, individuals with normal psychological functioning generally have more effective emotional regulation strategies. They are able to experience stress, anxiety, or frustration without these feelings overwhelming their body's physiological systems. Their emotional responses are more adaptive, meaning they can experience emotional discomfort but find ways to cope with it before it escalates into physical issues.

Another important psychological trait that differentiates psychosomatic individuals from those with normal functioning is the nature of their coping mechanisms. People with psychosomatic disorders often lack adaptive coping strategies. They may avoid confronting their emotional difficulties or might become overly anxious about their symptoms. This can create a cycle in which their psychological distress feeds into physical symptoms, reinforcing the belief that their condition is primarily physical rather than psychological.

In contrast, people with normal psychological functioning tend to exhibit more adaptive coping mechanisms. These may include problem-solving, seeking social support, or engaging in relaxation techniques such as mindfulness or deep breathing. Their ability to effectively manage stress and negative emotions helps to prevent the development of physical symptoms that could arise from emotional strain.

Individuals with psychosomatic conditions may also have lower levels of self-awareness or emotional insight. They may have difficulty recognizing the psychological origins of their physical symptoms, often attributing them to purely medical causes. This lack of awareness can prevent them from seeking appropriate psychological treatment and delay the process of healing. Furthermore, they may be less able to identify or articulate the emotional triggers that contribute to their physical ailments.

On the other hand, individuals with normal psychological functioning are generally more attuned to their emotions and the impact these emotions have on their physical health. They can recognize when stress or emotional turmoil is contributing to feelings of discomfort or illness, which allows them to address the root causes more effectively. This self-awareness is crucial for maintaining overall health and well-being, both physically and psychologically.

Certain personality traits, such as high levels of neuroticism or perfectionism, are commonly found in individuals with psychosomatic disorders. These traits can increase vulnerability to stress, leading to heightened emotional reactivity and a greater likelihood of physical symptoms developing in response to psychological distress. Conversely, people with normal psychological functioning often exhibit a more balanced or resilient personality, enabling them to manage life's ups and downs without their emotional states spiraling into physical health issues.

Treatment for psychosomatic disorders generally requires a multifaceted approach that addresses both the psychological and physical aspects of the condition. This often includes psychotherapy, particularly cognitive-behavioral therapy (CBT), relaxation techniques, and sometimes medication to manage stress or anxiety. In

comparison, individuals with normal psychological functioning may not require the same intensive interventions, although they can benefit from periodic psychological support or preventive care to maintain emotional health and well-being.

In conclusion, the comparison between psychosomatic individuals and those with normal psychological functioning reveals significant differences in emotional regulation, coping strategies, self-awareness, personality traits, and overall health. While both groups experience emotional challenges, those with psychosomatic conditions are more likely to have a maladaptive response to stress, which manifests physically. By understanding these differences, it becomes clear how early intervention and improved emotional coping can prevent the progression of psychosomatic disorders and promote a healthier, more balanced life.

Review of Literature

Engel, G.L.[1] (1977) introduced the concept of psychosomatic medicine and examined the interplay between psychological and physiological health. Engel argued that psychosomatic conditions arise when psychological factors significantly influence the onset, course, or outcome of physical disorders. The review focuses on how psychological stress, emotional conflicts, and interpersonal issues contribute to physical health problems like cardiovascular diseases, gastrointestinal issues, and chronic pain. So, Psychosomatic disorders are not simply psychological or physical but involve a complex interaction between the two. Kroenke, K., & Price, R.K.[6] (1993) investigated the psychological factors, such as depression and anxiety, that contribute to somatic symptoms. The authors explore how psychological disorders can manifest as physical symptoms in patients without clear medical explanations. They also discuss how depression and anxiety can exacerbate chronic illnesses, leading to a feedback loop where physical symptoms further increase psychological distress. Therefore, Psychological distress is a critical factor in the development and persistence of somatic symptoms. Fava, G.A., &Tomba, E.[2] (2009) focused on the application of cognitive-behavioral therapy (CBT) in treating psychosomatic disorders. The authors review several studies that support the efficacy of CBT in addressing both the psychological and physical aspects of psychosomatic disorders, such as irritable bowel syndrome, chronic pain, and fibromyalgia. Thus, CBT is an effective therapeutic tool for treating psychosomatic disorders by targeting dysfunctional thoughts and emotions that contribute to physical symptoms. Meyer, B., & Marks, M.[8] (2006) delved into how certain personality traits, such as high neuroticism, type A behavior, and perfectionism, are associated with a higher risk of developing psychosomatic symptoms. The authors argue that individuals with these traits may have difficulty managing stress, which increases their vulnerability to physical illnesses that stem from emotional disturbances. Thus, Personality traits like neuroticism and perfectionism can predispose individuals to psychosomatic disorders. Kiecolt-Glaser, J.K., & Glaser, R.[5] (2002) examined how chronic stress affects the immune system and contributes to a range of physical health problems, including cardiovascular diseases, infections, and autoimmune disorders. The authors discuss how prolonged psychological stress can impair immune function, making individuals more susceptible to illness. So, Chronic psychological stress has a direct physiological impact, contributing to the development of psychosomatic disorders. Gross, J.J.[4] (2002) focused on emotional regulation and its role in both mental and physical health. The author highlights how poor emotional regulation, particularly the suppression of negative emotions, can lead to psychosomatic symptoms. Chronic emotional suppression can cause physical manifestations of stress, such as headaches, muscle tension, and gastrointestinal problems. Thus, Effective emotional regulation is essential for preventing psychosomatic conditions. Emotional suppression can lead to both psychological and physical health issues. Langer, E.J.[7] (2009) emphasized the profound mind-body connection, exploring how beliefs and thoughts can influence physical health. Langer discusses how factors like mindfulness, attention, and awareness can alter the experience of physical symptoms, particularly in psychosomatic disorders. She also presents evidence showing that mindfulness can significantly reduce psychosomatic symptoms. So, Mindfulness and attention to the mind-body connection can reduce psychosomatic symptoms by changing how individuals perceive and respond to physical discomfort. Spinhoven, P., et al.[9] (2004) looked at the

various coping strategies employed by individuals with psychosomatic disorders and compares them to those of individuals with normal psychological functioning. It discusses the relationship between maladaptive coping mechanisms (e.g., avoidance, denial) and the worsening of physical symptoms. So, Maladaptive coping mechanisms are strongly linked to the persistence and exacerbation of psychosomatic symptoms, while adaptive coping strategies can reduce symptom severity. Walker, E.A., & Katon, W.[11] (1998) highlighted the cognitive and affective processes that underlie the development and maintenance of somatic symptoms in psychosomatic disorders. It explores how cognitive distortions, such as catastrophizing or hypervigilance to bodily sensations, can lead to a heightened awareness of physical symptoms and contribute to their persistence. Thus, Cognitive factors like catastrophizing contribute to the amplification of psychosomatic symptoms, highlighting the importance of cognitive restructuring in treatment. Gatchel, R.J., &Okifuji, A.[3] (2006) examined the role of psychological factors in the development and maintenance of chronic pain, a common manifestation of psychosomatic disorders. It explores how depression, anxiety, and negative emotional states contribute to the persistence of pain and the challenges associated with pain management. So, Psychological interventions, such as cognitive-behavioral therapy and relaxation techniques, can significantly reduce the severity of chronic pain in individuals with psychosomatic disorders. Tiwari, S., & Sinha, D.[10] (2015) focused on the role of family dynamics in the development of psychosomatic disorders. It looks at how dysfunctional family environments, including high levels of conflict or overprotectiveness, can increase the likelihood of individuals developing psychosomatic symptoms. The authors also examine how family therapy can improve outcomes for individuals with psychosomatic disorders. So, Family dynamics play a crucial role in both the onset and treatment of psychosomatic conditions, suggesting the importance of family interventions alongside individual therapy. It is to be noted here that psychosomatics have not been studied in context of stress, anxiety and depression especially in context of Patna (Bihar). This is why present study is undertaken.

Objective

The study intended to compare psychosomatics and normal in terms of stress, anxiety and depression.

Hypotheses

(1) The psychosomatic respondents would differ significantly from normal counterparts in terms of stress.

(2) The psychosomatic respondents would differ significantly from normal counterparts in terms of anxiety.

(3) The Psychosomatic respondents would differ significantly from their normal counterparts in terms of depression.

Method of Study

Sample Used

The sample comprised of psychosomatic (peptic ulcer; N = 50; bronchial asthma : N=50; diabetes : N=50; hypertension : N=50) and 50 normal to each of the family members to which the patients belong. The psychosomatics were selected from among Government hospitals, private hospitals as well private clinics. The subjects were matched in respect of sex, inhabitation and other than the research condition.

Tools Used

(1) A PDS was used to seek the personal information about the respondents.

(2) Stress Scale (SPSSI) by A.K. Singh was used to measure the level of stress amongst the respondents.

(3) Sinha's Manifest Anxiety Scale was used to measure the level of anxiety amongst the respondents.

(4) Depression Inventory by Krug, S. and Laughlin, J.E. was used to measure the depression amongst the respondents.

Results and Interpretations

Table 01: t-ratio showing the comparison between the normal subjects and the psychosomatic patients in terms of stress

Respondents	N	Mean	SD	t-matrix	df	p
a. normal	50	63.03	3.37			
				t_{ab} = 10.21	98	<.01
b. Peptic ulcer	50	70.29	3.64			
				t_{ac} = 9.77	98	<.01
c. Bronchial Asthma	50	69.97	3.70			
				t_{ad} = 10.25	98	<.01
d. Diabetes	50	70.31	3.75			
				t_{ae} = 10.29	98	<.01
e. Hypertensive	50	70.44	3.81			

It is clear from the result table-01 that normal respondents differ significantly from peptic ulcer groups of patients (t_{ab} = 10.21; df = 98; p<.01), bronchial asthma group of patients (t_{ac} = 9.77; df = 98; p<.01), diabetes group of patents (t_{ad} = 10.25; df = 98; p<.01), and hypertensive group of patients (t_{ac} = 10.29; df = 98; p<.01) on the measure of stress. Psychosomatic patients with conditions like peptic ulcers, bronchial asthma, diabetes, and hypertension manifest higher levels of stress compared to their normal counterparts because chronic stress exacerbates both the onset and progression of these disorders. These conditions are closely linked to emotional strain, anxiety, and lifestyle disruption. Moreover, managing ongoing symptoms, adhering to treatments, and fearing complications create a feedback loop of psychological burden. Unlike healthy individuals, these patients face both physical and emotional challenges, intensifying overall stress levels.

Table 02: t-ratio showing the comparison between the normal subjects and the psychosomatic patients in terms of anxiety

Respondents	N	Mean	SD	t-matrix	df	p
a. normal	50	73.80	3.80			
				t_{ab} = 10.59	98	<.01
b. Peptic ulcer	50	81.85	3.74			
				t_{ac} = 11.12	98	<.01
c. Bronchial Asthma	50	82.14	3.65			
				t_{ad} = 9.84	98	<.01
d. Diabetes	50	82.36	3.60			
				t_{ae} = 10.87	98	<.01
e. Hypertensive	50	81.95	3.70			

It is clear from the result table-02 that normal respondents differ significantly from peptic ulcer groups of patients (t_{ab} = 10.59; df = 98; p<.01), bronchial asthma group of patients (t_{ac} = 11.12; df = 98; p<.01), diabetes group of patents (t_{ad} = 9.84; df = 98; p<.01), and hypertensive group of patients (t_{ac} = 10.87; df = 98; p<.01) on the measure of anxiety. Normal respondents excelled over their each psychosomatic group of patients in terms of having higher degree of anxiety. Thus, hypothesis no. (02) is retained. Psychosomatic patients with conditions like peptic ulcer, bronchial asthma, diabetes, and hypertension manifest higher levels of anxiety than their normal counterparts because these chronic illnesses are closely linked to stress and emotional dysregulation. The persistent nature of these conditions, fear of complications, and lifestyle restrictions increase psychological burden. Additionally, anxiety can exacerbate physical symptoms, creating a vicious

cycle where the mind and body continuously affect each other, intensifying both physical illness and emotional distress.

Table 03: t-ratio showing the comparison between the normal subjects and the psychosomatic patients in terms of depression

Respondents	**N**	**Mean**	**SD**	**t-matrix**	**df**	**p**
a. normal	50	22.65	3.12			
				t_{ab} = 12.20	98	<.01
b. Peptic ulcer	50	30.46	3.35			
				t_{ac} = 12.37	98	<.01
c. Bronchial Asthma	50	30.69	3.42			
				t_{ad} = 11.69	98	<.01
d. Diabetes	50	30.25	3.29			
				t_{ae} = 12.00	98	<.01
e. Hypertensive	50	30.33	3.36			

It is clear from the result table-03 that normal respondents differ significantly from peptic ulcer groups of patients (t_{ab} = 12.20; df = 98; p<.01), bronchial asthma group of patients (t_{ac} = 12.37; df = 98; p<.01), diabetes group of patents (t_{ad} = 11.69; df = 98; p<.01), and hypertensive group of patients (t_{ac} = 12.00; df = 98; p<.01) on the measure of depression. Psychosomatic patients with conditions like peptic ulcer, bronchial asthma, diabetes, and hypertension manifest higher levels of depression than their normal counterparts due to the chronic nature of their illnesses, constant physiological discomfort, and lifestyle limitations. These conditions often involve ongoing stress, fear of complications, dependence on medication, and reduced quality of life. Additionally, the mind-body connection in psychosomatic disorders can amplify emotional distress, leading to a cycle where psychological strain worsens physical symptoms and vice versa, increasing vulnerability to depression.

Conclusions

(1) High stress is significant contributor to the growth and development of psychosomatic disorder. So, stress is an etiological factor for the growth and development of psychosomatic disorders.

(2) High anxiety is significant contributor to the growth and development of psychosomatic disorder. So, anxiety is an etiological factor for the growth and development of psychosomatic disorders.

(3) High depression is significant contributor to the growth and development of psychosomatic disorder. So, depression is an etiological factor for the growth and development of psychosomatic disorders.

Bibliography

1. Engel, G. L. (1977) The need for a new medical model: A challenge for biomedicine. *Science,* 196(4286), 129–136. https://doi.org/10.1126/science.847460

2. Fava, G. A. &Tomba, E. (2009) Increasing psychological well-being and resilience by psychotherapeutic methods. *Journal of Personality,* 77(6), 1903–1934. https://doi.org/10.1111/j.1467-6494.2009.00604.x

3. Gatchel, R. J. & Okifuji, A. (2006) Evidence-based scientific data documenting the treatment and cost-effectiveness of comprehensive pain programs for chronic nonmalignant pain. *The Journal of Pain,* 7(11), 779–793. https://doi.org/10.1016/j.jpain.2006.08.005

4. Gross, J. J. (2002) Emotion regulation: Affective, cognitive, and social consequences. *Psychophysiology,* 39(3), 281–291. https://doi.org/10.1017/S0048577201393198

5. Kiecolt-Glaser, J. K. & Glaser, R. (2002) Depression and immune function: Central pathways to morbidity and mortality. *Journal of Psychosomatic Research,* 53(4), 873–876. https://doi.org/10.1016/S0022-3999(02)00309-4

6. Kroenke, K. & Price, R. K. (1993) Symptoms in the community: Prevalence, classification, and psychiatric comorbidity. *Archives of Internal Medicine,* 153(21), 2474–2480. https://doi.org/10.1001/archinte.1993.00410210060006

7. Langer, E. J. (2009) Mindfulness and the mind-body connection. In *Counterclockwise: Mindful health and the power of possibility*, p. 103–129, Ballantine Books, New York.

8. Meyer, B. & Marks, M. (2006) Personality characteristics of individuals with somatoform disorders. *Current Psychiatry Reports,* 8(3), 205–210. https://doi.org/10.1007/s11920-006-0027-2

9. Spinhoven, P.; Van der Does, A. J. W.; Van Dijk, E. & van Rood, Y. R. (2004) Coping styles and somatic health problems in patients with unexplained physical symptoms. *Journal of Psychosomatic Research,* 57(4), 367–373. https://doi.org/10.1016/j.jpsychores.2003.12.003

10. Tiwari, S. & Sinha, D. (2015) Family environment and psychosomatic problems. *Indian Journal of Health and Wellbeing,* 6(7), 701–705.

11. Walker, E. A. & Katon, W. (1998) Somatization revisited: Diagnosis and management of somatizing patients. *Archives of Internal Medicine,* 158(8), 905–913. https://doi.org/10.1001/archinte.158.8.905

——==00==——