

Psychosocial Stress and Low Resilience: A Risk Factor for Hypertension. Relations between Hypertension and Psychoanalysis

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“When a disease occurs in a massive way, it reflects cultural problems”
Virchow (1821-1902).

The introduction of Dr. Costa de Robert et al.’s work begins like this. (1)

Contemporary of Virchow, Sigmund Freud (1856-1939) deals with culture which is undoubtedly his masterpiece, “The civilization and its discontents”, published in 1930. (2)

There, three sources of human suffering are listed: one internal, associated to our body which is condemned to decline and annihilation, other external, nature, capable of enrage with implacable and destructive forces, and a third one, associated to the work I mentioned, our failure to regulate social relationships.

The work emphasizes that suffering from the third force mentioned is more painful than any other. And we will see how this suffering is connected with psychosocial stress.

On the other hand, the word is the cornerstone of our life relationships, our interaction with society and culture. And the word in the medical interview appears surrounded by doubts, fears, anxieties, worries, etc.

Within the medical words, hypertension is undoubtedly one of the most clear and convincing one with regard to the relationship soma-psyche.

Psychoanalysis makes the word a basic spring of treatment, as an interventionist cardiologist and psychoanalyst, I would ask a patient that consults me about hypertension: To what is referred the word hyper-tension?, separating the two parts of the word, to begin an open consultation in order to know the psychosocial aspects of his discomfort which is expressed in the increase of his blood pressure.

Dr. Costa de Robert et al.’s work is surprisingly pleasant, especially if we consider that in hypertension consensus of our Argentine Society of Cardiology the word stress is mentioned only once, psychosocial aspects are mentioned vaguely and the word resilience does not appear. (3)

Surprising and impressive, to my mind, as it is mentioned in the consensus regarding therapies to reduce stress, “there are no data about studies

with greatest statistical power which guarantee the use of these techniques”, as J. D Nasio (argentine psychoanalyst settled in France) says, “the body in general and the organ injury in particular are exactly correlative to the onset of the instrument to detect them or to the drugs to treat them”. (4)

Resilience comes from Latin *resilio* (*re-salio*), which means jump, bounce, and come around again. The term is used in civil engineering and metallurgy to calculate the capacity of certain materials to recover themselves, return to their original position when they have suffered certain loads or a factor that distorted them.

In medicine, resilience is a concept that rose in child psychiatry to describe children’s behaviour especially those who have had successful adaptive development, despite adverse context conditions that predicted the contrary. Subsequently, this concept is extended to individuals of any age in different contextualized conditions as it appears in the present work.

The international leader in the development of the resilience paradigm is Boris Cyrulnik, who says that resilience is the combination of the innate and the acquired and that the possibility of resilient development depends on personal temperament, cultural significance and social support. It is the capacity that some human beings develop in order to overcome psychological trauma and serious emotional wounds, such as mourning, rape, torture, deportation, war, and physical, psychic or moral violence. (5)

On the other hand, the resilience concept is countered to the vulnerability concept. The higher the resilience, the lower the vulnerability, as it is shown in the study.

Somatic vulnerability is for medicine and for psychoanalysis the probability of dysfunctional (hypertension) and behavioral responses when facing stress factors or adverse conditions.

Resilience, moreover, is modifiable; the scale used by authors show that resilience may improve with medication and psychological treatment.

Therefore, can we change a vulnerable and hypertensive individual into a resilient and normotensive one? How? Modifying, which factors?

Stress, or general adaptation syndrome, was

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described by Seyle as a group of symptoms and signs that occurred in organisms that had to support a struggle which, extended to a highest level of alert, culminated in a general adaptation disease.

For cognitive theories, it is a response to a threatening cognition or stimulation which consists in the increment of body activation more quickly than its capacity to ease it.

When facing a threatening situation, the body is adapted through several areas: psychophysiological, psychoendocrine, behavioral and psycho-immunologic.

We all have demands and pressures from the environment and/or our inner world.

However, when facing these inner and outer demands, we have to analyze the available options that determine the resilience-vulnerability degree.

Stress with negative connotations is known as distress and it may lead to dysfunctions, different disorders, diseases and death, while stress with positive connotations is known as eustress and it is a basic way of motivation.

Beyond the elements that characterize stress as an idea of excitation which deals from the outer world, psychoanalysis says that there are affections that mind has not processed yet (primary flaws in ties, flaws in the constitution of the self, children's trauma) that may act from the individual's inner self as an excitation augmentatives which exceed the psychic capacity with a shock of diffuse anxiety, depression, emptiness and all kind of somatic manifestations.

With great criterion, authors revise and take INTERHEART's criteria, categorical study regarding the stress connection and cardiovascular disease, in this case, the myocardial infarction. (6)

The conclusions of the INTERHEART study show that labor and financial stress, stress at home and all the life-stressing events which took place in the last year were associated to a high risk of acute myocardial infarction.

Recently, an INTERSTROKE study has been published, as the INTERHEART study mentioned before, it is a worldwide study developed to establish the association of well-known risk factors and others that emerged as a consequence of ischemic and hemorrhagic strokes. (7)

Its findings show consistently that the history of hypertension is the major risk factor for a stroke event and that labor and domestic stress (psychosocial stress for the authors), as depression, are associated to a major risk of having a stroke.

After the appearance of these two studies, from which clearly arise that psychosocial factors are associated to a major risk of having a myocardial

infarction and a stroke; it is inconceivable not to consider, evaluate and modify them not only in hypertensive patients but in all patients that have a cardiovascular pathology.

The results of Costa de Robert et al.'s work does not fit in the objective of detecting if low resilience together with chronic psychosocial stress produce subclinical damage in target organs. Probably, it will be evaluated in a future work.

The determination of the 25th percentile of the normal as a value of low resilience belongs to the authors' opinion and it is subject to criticism.

The sample is small but the potential population, the simplicity of the data and the questionnaires to be gathered make easier the extension of the number of patients in future works which will give a major statistical weight.

Preliminary data mentioned by the authors have a great clinical value.

The chronic psychosocial stress and resilience should be part of the data to be gathered in any interview done to a hypertensive patient.

In all patients in which we find a relationship between chronic psychosocial stress and decreased resilience, mental health consultation is urgent.

We should remember that resilience may be modified and one of the most important weapons to increase it is social support.

The adequate magic word, after an attentive monitoring, is the first support that patients have.

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