Anxiety and Psychosomatics: The Way in Which Anxiety States and Disorders Affect the Body

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Abstract:

The awareness of the relationship between mind and body is far from being new. Until about 300 years ago, every medical system in the world treated the mind and body as a whole. But, starting with the 17th century, the Western world began to see mind and body as two distinct entities. According to this view, the body was seen as a kind of machine, complete with independent, replaceable parts, without any connection to the mind. In the 20th century, this view gradually began to change. Teams of researchers began to study the mind-body connection and, scientifically, proved the existence of the complex connection between the body and the mind.

The purpose of this paper is to verify if anxiety represents one of the determinant and triggering factors of the psychosomatic diseases and disorders, especially in the context of the pandemic period from the last three years and of the global crisis, by conducting a study involving two groups of people. By analysing the results of the evaluation instruments used for the two groups, we have found out that anxiety, as a trait, leads to psychosomatic diseases.

Keywords: anxiety, psychosomatics, mind-body connection.

Introduction

Anxiety is a pervasive phenomenon affecting individuals at various levels of well-being, manifesting in both physiological and psychological forms of discomfort. It frequently impairs the ability to derive enjoyment from life and limits engagement in everyday activities. The complexity of anxiety has drawn the attention of numerous scholars, given its profound impact on human functioning. As it is widely acknowledged, emotions exert a considerable influence on the body, with anxiety frequently producing symptoms that range from transient discomfort to more severe psychosomatic illnesses.

This study explores anxiety through both theoretical and practical lenses. The theoretical section synthesizes key theories on the nature and manifestation of anxiety, elucidating its various forms and highlighting the relationship between anxiety and psychosomatic conditions. It also provides a comprehensive review of psychosomatic illnesses, detailing their characteristics and underlying mechanisms.

The practical component of this research is grounded in empirical analysis. It involves the administration of questionnaires to two distinct groups: patients diagnosed with psychosomatic disorders who are currently hospitalized in the Internal Medicine Department of the County Emergency Hospital of Craiova, and a control group of adults who are not hospitalized and do not suffer from psychosomatic conditions. The objective of this comparison is to investigate the role of anxiety as a significant determinant and precipitating factor in the development of psychosomatic disorders.

The aim of this research is to substantiate the hypothesis that anxiety serves as one of the primary triggers of psychosomatic diseases, particularly in light of the heightened stressors brought about by recent global events, such as the COVID-19 pandemic and the accompanying economic crises. By drawing on both theoretical frameworks and empirical evidence, this paper seeks to contribute to the growing body of literature on the interplay between psychological factors and physical health, with a specific focus on the role of anxiety in the etiology of psychosomatic disorders.

Literature Review

The term "anxiety" comes from the Latin "anxietas" It represents a general psychophysical state, characterized by a feeling of unease, insecurity and lack of calm in the face of what is, evidently, an imminent threat of indeterminate cause. The difference between normal and pathological anxiety is that the latter is based on an unreal or distorted evaluation of the threat. When anxiety is very severe and acute, it can "paralyze" the individual, turning into panic. The World Health Organization states that there are data showing that 20% of the world's population suffers from anxiety. The estimated number of people who have suffered from anxiety at some point in their lives is 400 million worldwide (World Health Organization. Mental Health, 2009).

The Roland Doron and Francoise Parot (2006) Dictionary of Psychology defines anxiety as: "an emotion generated by the anticipation of a diffuse, hard-to-foresee, and uncontrollable danger; it turns into fear in the face of a well-identified danger, accompanied by physiological and hormonal changes characteristic of high activation states and often associated with preservation-withdrawal behaviour or avoidance conduct."

Rojas (2014) considers that anxiety is a feeling of fear towards something diffuse, vague, undefined, which, unlike fear, has an explicit reference. Anxiety is an emotion accompanied by adrenergic reactions such as sweating, muscle tension, tremor, agitated breathing, headache, back pain, chest pain, heart palpitations, stomach pain, among other signs and symptoms that obstruct the body, and when the intensity levels increase, they make the person unable to adapt well to daily life, considering this a serious problem causing anxiety disorders.

Inefficiency in adaptation occurs in the case of chronic repetitive worries, causing a real emotional blockage when the human subject focuses attention on a single point of view, reflecting rigidity. Goleman (2018) believes that, in this case, at the neurological level, there is a deficit in the emotional brain's capacity to react flexibly to changing circumstances. Those affected by chronic worry, fear things that mostly cannot happen or for problems that others

do not foresee. The habit they acquire – of worrying – deepens similarly to superstitions; thus, they become convinced that in this way they prevent the danger that obsesses them. If this process persists and intensifies, anxiety disorder sets in.

Nothing is less clear than the finality of fear, once it exceeds a certain limit; below this limit, we perceive a certain timidity so useful to our adaptation to the environment, while the paroxysms of fear only harm those who fall victim to them. Related to this last fact, psychopathologists identify the following maladjustment disorders within the group of irrational fears: anxiety, phobias, and panic attacks. Holdevici (2011) makes the following distinction between them, presenting them as follows:

- Anxiety - diffuse fear, without a well-specified object; the subject experiences continuous tension, feeling constantly threatened; he is very nervous and often does not even realize what scares him so much;
- Phobia - persistent fear of an object, thought, or situation that does not usually justify the fear; the subject realizes that his fear is ridiculous, senseless, fights against it but cannot overcome it;
- Panic - sudden and acute surge of terror.

Mitrofan (2013) views anxiety as a fear without an object, unease accompanied by intrapsychic tension, agitation, irritability, and somatic symptoms.

Anxiety manifests at the level of the three tiers of the human being: physiological, psychological, and behavioural:

- At the physiological level, anxiety causes dizziness, a lump in the throat, abundant sweating, tachycardia, etc.;
- At the psychological level, there is a state of apprehension, fear of imminent danger, accompanied by general discomfort. In extreme forms, the subject may feel detached from his own person or frightened by the thought that he will die or go insane;
- At the behavioural level, anxiety can compromise the subject's ability to act, express himself, and cope with situations.

Anxiety can be caused by a mental condition, a physical condition, as a cause of the effects of medication or from a combination of these. The initial task of the doctor is to see if anxiety is caused by a medical condition. Conditions as varied as anaemia, asthma attack, infection, intoxication, or drug use, or a series of heart conditions are just a few examples of medical problems that can be associated with anxiety (Holdevici, 2011).

According to DSM V, common types of anxiety are classified into several distinct mental conditions:

- Panic disorders: Besides anxiety attacks, called panic attacks, common symptoms of panic disorders include stomach disorders, palpitations (the sensation of the heart beating), dizziness, and shortness of breath. The same symptoms can also be caused by caffeine consumption, amphetamines ("speed" is the street slang for amphetamines when not prescribed by a doctor), an overactive thyroid, abnormal heart rhythms, and other cardiac abnormalities (such as mitral valve prolapse). People experiencing panic attacks may feel that their mind will cope or that, in some way, they do not feel real, feeling as if they are observing themselves. To qualify for the diagnosis of panic disorder, the individual would have repeated panic attacks, rather than a single episode, according to DSM-V.

- Generalized anxiety disorder: Those suffering from this condition experience numerous worries that are more often on the mind of the sufferer. These worries interfere with the person's ability to sleep, frequently affect appetite, energy level, concentration, and other aspects of daily functioning, according to DSM-V.
- Phobic disorders: People with phobias experience irrational fear that can rise to the level of panic attacks in response to a specific thing or situation. Examples of phobias include fears of spiders, insects in general, open spaces, closed spaces, air travel, heights, and social anxiety.
- Separation anxiety disorder: Considered a children's disorder, separation anxiety disorder can be diagnosed when a child becomes extremely distressed in response to anticipating or separating from one or more adult caregivers (usually a parent) (Feriante et al., 2023).
- Agoraphobia: An anxiety disorder that manifests as fear of various situations that can happen outside the home. Most cases of agoraphobia start around the age of 20 and are preceded by panic attacks. Physical symptoms may include dizziness, chest pains, and shortness of breath, according to DSM-V.
- Selective mutism refers to the inability of children to communicate verbally in certain social situations, although they have demonstrated their ability to speak within the family (Nita, 2014).
- Social anxiety disorder: describes intense avoidance and fear concerning negative public appraisal, public embarrassment, humiliation, or social interaction; this can be specific to particular social situations (such as public speaking) or is experienced in most social interactions (Alomari et al., 2022).

Treatment depends on the cause of anxiety. When the cause of anxiety is a physical condition, treatment is directed towards eliminating this condition. For example, if the thyroid gland has been overactive and caused anxiety, treatment might involve surgery and various medications that regulate the thyroid. When the cause is psychological, the underlying cause must be discovered and, if possible, eliminated or controlled. For example, if the cause is marital problems, the doctor may suggest marital counselling. Sometimes, the cause cannot be identified. In such cases, the only treatment option is symptom control.

Continuing with the second part of our theoretical research, we mention that "the term *psychosomatics* designates the concept that unites Spirit and Body into a global unit within which any function or condition of one is associated with changes in the other" (Grinker, 1959).

Starting from the idea of Grinker & Robins (1958), we can state that psychosomatics is the psychological disorder that generates a physical effect, causing a certain consequence in the body. It can be said, therefore, that a psychosomatic condition originates in the psyche and then exerts a certain influence on the body. In other words, classifying a disease or condition as psychosomatic implies attributing an emotional cause to it. In any case, the exact knowledge of the importance of the mind in the development of this disorder is impossible for science because variables that cannot be quantified come into play.

From this point of view, we agree with Holland (1901), who stated that "there is almost no physical condition in which an emotion or a certain mental function is not involved, directly or indirectly, as an effect or cause".

Studying the specialized literature, Pierloot (1956) distinguishes four groups of definitions of psychosomatics, which we present below, according to Enăchescu & Enăchescu (2008):

1. Psychosomatics is the general study of the relationship between certain psychic phenomena and certain psychosomatic phenomena; the "psychic" and the "somatic" are considered different manifestations of the same form of human existence.
2. Clinical psychosomatics represents the study of the relationship between psychic phenomena and somatic phenomena, applied in the context of understanding and explaining the sufferings of the patient.
3. In general, psychosomatic disorder is understood to mean any kind of somatic condition to the extent that it can be demonstrated that it is determined by neurotic psycho-traumatizing factors.
4. In a narrow sense, psychosomatic disorder means symptoms or syndromes in which the influence of psychic factors can be clearly delineated and studied."

According to DSM-V, psychosomatic disorders are called somatoform disorders and are divided into seven groups, as follows: somatization disorder (or hysteria), undifferentiated somatoform disorder, conversion disorder, pain disorder, hypochondria, body dysmorphic disorder, and somatoform disorder not otherwise specified.

Therefore, we can consider that psychosomatics is a synthesis between somatic medicine (general medical pathology) and psychiatry (mental pathology).

Psychosomatics is defined as "a scientific discipline aimed at studying the relationship between biological, psychological, and social factors that explain the state of illness and the state of health," with the corollary of diagnostic and therapeutic holistic global approach to the patient (Tatayeva et al., 2022).

Psychosomatic medicine emphasizes the involvement of psychological and social factors in the etiology of diseases, highlighting at the same time "the interrelation between the body, the psyche of the individual, and his social environment" (Grinker, 1959).

Another definition of psychosomatic medicine is proposed by Kimball (2005): "A designation used by those physicians who, through research and clinical activity, have come to believe and practice that human disease cannot be conceived or treated using the cause-disease approach, given that in each disease there are many factors involving the individual's somatic and psychological processes and their relationship with the environment.

Similarly, Deter et al. (2018) consider that the psychosomatic approach encourages the physician to pay the same attention to the mental processes of the patients as to the organic processes.

There are numerous examples of psychosomatic processes. Some are very simple and do not involve a disease: when a person is embarrassed about something, their cheeks change colour; in other words, the subject blushes. This physical change follows a psychic process.

A state of nervousness can also trigger psychosomatic processes. An adolescent who is about to take a test may experience tachycardia and excessive sweating of the palms. A person involved in a street argument over a traffic problem may, on the other hand, have an increase in blood pressure (Grigorian et al., 2023).

When psychological imbalance extends over time and does not involve a single extraordinary situation, the psychosomatic problem can be persistent. A person suffering from an anxiety disorder with panic attacks may repeatedly suffer from dizziness, colitis, chest pains, and nausea.

Psychosomatic medicine is a complex method of addressing patients, the etiology, pathogenesis, and therapeutics of pathological phenomena, in which psychic factors play a pathogenic role or are related to their therapy (Tatayeva et al., 2022).

Many authors see psychosomatic medicine as a healthy reaction to depersonalized medicine that had emerged as a result of extreme specialization and which, through increasing reliance on technical means in diagnosis and treatment, had fundamentally changed the relationship between doctor and patient. The psychosomatic approach involves a fundamental change in medical attitudes, also incorporating psychological aspects in the diagnosis and treatment of various conditions (Deter at al., 2018).

Psychosomatic disorders have different characteristics and can be divided into the following main groups (Alexander, 2008):

- Conversion symptoms consist of a secondary somatic response and the development of a neurotic conflict. The symptoms have a symbolic character and can be considered as an attempt to resolve the conflict. They relate to the motor and sensory organs (e.g., hysterical paralysis, paresthesia, psychogenic blindness, deafness, vomiting, and various pain sensations).
- Functional syndromes are present in a large number of patients who consult the doctor, having a shifting spectrum of suffering, often diffuse. They refer to the cardiovascular system, gastrointestinal tract, musculoskeletal system, respiratory organs, or urogenital tract. Although functional disorders involving certain organs and systems are present, in most cases there is no evidence of tissue damage. These features are accompanying signs of affect and do not have an expressive character, being called by Alexander (2008), organ neuroses.
- Psychosomatic disorders in the narrow sense hide behind them a physical reaction to a conflictual situation or stress. The reaction is accompanied by morphologically demonstrable tissue lesions and the demonstration of organic changes. The choice of organs is also influenced by a predisposition. The seven ‘sacred’ psychosomatic conditions are: bronchial asthma, ulcerative colitis, essential hypertension, neurodermatitis, rheumatoid arthritis, duodenal ulcer, and anorexia.

Initially, the manifestations are reversible, but as symptoms repeat, they can establish an altered medical condition by weakening the general resistance of the body or affecting the functions of certain organs. In general, psychosomatic conditions center on certain preferred organs: in the digestive sphere, respiratory and allergic sphere, or cardiovascular sphere, etc. (Zhang et al., 2022).

Research Methodology

The objective of the work is to achieve a correlation between trait anxiety and the occurrence of psychosomatic diseases. Increased perception of stress may be associated with a moderate level of anxiety, depression symptoms, interpersonal sensitivity, frustration, and helplessness. When associated with anxiety and depression, stress can influence the quality of life and reduce academic performance due to difficult cognitive functioning induced by anxiety, such as memory disorders, blocking, inability to make decisions, and increased

sensitivity to others' judgments. As a psychological and physiological state, anxiety is considered a normal response to stress, but prolonged exposure and higher perceived stress levels can lead to adverse consequences, including the development of anxiety disorder.

This research adopts a descriptive, descriptive-comparative, and correlational study. It is descriptive in that it provides an extensive review of theoretical aspects, including definitions, characteristics, and the core features of the key concepts under investigation. The study is also descriptive-comparative, as it examines two distinct groups, allowing for the measurement of anxiety levels in each group and facilitating contrastive analysis. Furthermore, it is correlational, as it seeks to explore the relationship between two concepts: trait anxiety and psychosomatic conditions.

The sample comprises two groups: the first group includes 30 men and women diagnosed with psychosomatic disorders who are hospitalized in the Internal Medicine Department of the County Emergency Hospital of Craiova, while the second group consists of 30 adult men and women without psychosomatic conditions and not currently hospitalized.

To assess anxiety levels, the study employed the State-Trait Anxiety Inventory (S.T.A.I. X2), with data processed using the SPSS statistical program to facilitate comparative analysis between the two groups. The State-Trait Anxiety Inventory (S.T.A.I.) consists of 2 self-evaluation scales for measuring two distinct concepts regarding anxiety: state anxiety (A-state) and trait anxiety (A-trait). Although initially created as a research instrument for investigating anxiety in 'normal' adults (without psychiatric problems), S.T.A.I. has proven to be useful in measuring anxiety in students as well as patients in the neuropsychiatric field, those in medical clinics or surgical services.

According to the study, we chose two different groups of subjects, namely 30 people suffering from psychosomatic diseases (Group 1, see Table 1) and 30 healthy people (Group 2, see Table 2). The subjects completed the S.T.A.I. X2 questionnaire, which aims to measure anxiety levels. The questionnaires were administered to each person individually, and the results were communicated. They were applied on paper, calculated, and then entered into the SPSS statistical program, which allowed us to find correlations between the anxiety levels in the two groups to finalize the case study.

Table 1. Group 1 - Persons with psychosomatic illnesses (PP)

		S.T.A.I. X2
Valid	PP1	74
	PP2	70
	PP3	55
	PP4	69
	PP5	72
	PP6	76
	PP7	65
	PP8	77
	PP9	60
	PP10	59
	PP11	53
	PP12	73
	PP13	74
	PP14	74
	PP15	53

		S.T.A.I. X2
	PP16	49
	PP17	59
	PP18	72
	PP19	74
	PP20	75
	PP21	68
	PP22	69
	PP23	76
	PP24	77
	PP25	70
	PP26	63
	PP27	66
	PP28	59
	PP29	58
	PP30	72
	Total	67.0333

Table 1 presents the individual scores of 30 participants from Group 1, composed of individuals with psychosomatic illnesses (denoted as "PP"), based on the results of the State-Trait Anxiety Inventory (STAI X2) questionnaire. Each participant (PP1 to PP30) received a specific score reflecting their level of trait anxiety. The scores range from 49 to 77, indicating a wide variability in anxiety levels within this group. The Table 1 concludes with the average STAI X2 score for Group 1, which is 67.03. This mean score suggests a generally high level of trait anxiety among individuals with psychosomatic illnesses, indicating a significant presence of anxiety-related issues within this population.

Table 2 presents the individual scores of 30 participants from Group 2, consisting of healthy individuals (denoted as "HP"), based on their results from S.T.A.I. X2 questionnaire. Each participant (HP1 to HP30) received a score representing their level of trait anxiety. The scores range from 20 to 45, indicating generally lower levels of anxiety compared to the group with psychosomatic illnesses.

Table 2. Group 2 – Healthy persons (HP)

		S.T.A.I. X2
Valid	HP1	26
	HP2	25
	HP3	30
	HP4	20
	HP5	32
	HP6	33
	HP7	25
	HP8	24
	HP9	23
	HP10	22
	HP11	26
	HP12	28
	HP13	29
	HP14	31

		S.T.A.I. X2
	HP15	32
	HP16	33
	HP17	40
	HP18	44
	HP19	45
	HP20	41
	HP21	42
	HP22	22
	HP23	26
	HP24	26
	HP25	27
	HP26	28
	HP27	29
	HP28	31
	HP29	33
	HP30	35
	Total	30.2666

Table 2 concludes with the average STAI X2 score for Group 2, which is 30.27. This relatively low mean score reflects a lower prevalence of trait anxiety among the healthy individuals, consistent with the assumption that they experience fewer anxiety-related issues compared to those with psychosomatic conditions. The contrast between the average scores of Group 1 and Group 2 highlights the significant difference in anxiety levels between these two populations.

The *t*-test for independent samples was conducted to determine whether there is a statistically significant difference in the mean scores of the S.T.A.I. X2 between the two groups: The aim of this analysis is to assess if the anxiety levels, as measured by the S.T.A.I. X2, differ meaningfully between these two distinct populations (see Table 3)

Table 3. Group statistics

	Group	N	Mean	Std. Deviation	Std. Error Mean
S.T.A.I.	Persons with psychosomatics diseases	30	67.0333	8.22730	1.50209
	Healthy persons	30	30.2667	6.67436	1.21857

Applying the *t* test for independent samples for S.T.A.I. X2, we can show the key descriptive statistics for both groups, as follows:

- Group of persons with psychosomatic diseases (N = 30): This group has a mean S.T.A.I. X2 score of 67.03, with a standard deviation of 8.23 and a standard error of 1.50. This indicates that the anxiety levels in this group are relatively high and show some variability.
- Group of healthy persons (N = 30): This group has a mean S.T.A.I. X2 score of 30.27, with a standard deviation of 6.67 and a standard error of 1.22. The lower mean reflects significantly lower anxiety levels in this group compared to the group with psychosomatic diseases.

Table 4 provides results from both Levene's Test for Equality of Variances and the t-test for Equality of Means. Levene's Test for Equality of Variances checks if the variances between the two groups (persons with psychosomatic illnesses and healthy persons) are equal. In this case, the significance value (Sig.) is 0.092, which is greater than the typical threshold of 0.05. This suggests that the variances between the two groups are not significantly different, meaning we could normally proceed with assuming equal variances.

Table 4. Independent samples test

Levene's Test for Equality of Variances			t-test for Equality of Means						
S.T.A.I.	F	Sig.	T	Df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of Difference	
								Lower	Upper
Equal variances assumed	2.934	.092	19.009	58	.000	36.76667	1.93422	32.89491	40.63842
Equal variances not assumed			19.009	55.635	.000	36.76667	1.93422	32.89141	40.64193

Despite the outcome of Levene's test, the explanation suggests you've chosen to interpret the results assuming unequal variances (second row), possibly for greater rigour:

- The t-value is 19.009, and the degrees of freedom (df) is 55.635.
- The p-value (Sig. 2-tailed) is 0.000, which is less than 0.05, indicating a statistically significant difference in anxiety scores between the two groups.
- The mean difference is 36.77, meaning that on average, individuals with psychosomatic illnesses scored 36.77 points higher on the S.T.A.I. X2 anxiety test than healthy individuals.
- The 95% Confidence Interval for the mean difference ranges from 32.89 to 40.64, which means we are 95% confident that the true difference in mean scores lies within this range.

Given these results, the difference in anxiety levels between the two groups is statistically significant, confirming that individuals with psychosomatic illnesses have significantly higher anxiety scores compared to healthy individuals. The p-value of 0.000 strongly supports the conclusion that this difference is not due to random chance.

Conclusion

The findings from our study confirm the proposed objectives and hypotheses, clearly indicating that hospitalized patients suffering from psychosomatic illnesses experience significantly higher levels of trait anxiety than healthy individuals. This correlation suggests that anxiety is not only a symptom but also a key factor that intensifies or causes the onset of psychosomatic disorders. Through our comparative analysis with other studies, it becomes evident that anxiety is a powerful predictor of these conditions. Moreover, our research underscores the strong correlation between intense emotional experiences and the development of psychosomatic illnesses, demonstrating that emotions such as anxiety, fear, and stress can manifest physically in the body.

Further supporting this notion, research conducted by a team[1] from Iași highlights the significant role emotions play in the onset of specific physical conditions, such as gastrointestinal and nutritional disorders. Their findings showed that anxiety, stress, and emotional conflicts, which provoke hostile reactions, lead to increased gastric hyperacidity. Prolonged exposure to these stressors results in mucosal changes that can cause chronic conditions like gastritis. This reinforces the notion that psychosomatic illnesses arise from the physical consequences of emotional and mental stressors.

Similarly, the work of Casado Morales (2002) in Spain found that patients with hypertension exhibit much higher levels of anxiety compared to healthy subjects. These findings, in conjunction with our own, demonstrate a recurring pattern in the literature: anxiety is a significant and consistent factor in the onset and progression of psychosomatic illnesses. The evidence aligns closely with our study's results, reinforcing the conclusion that anxiety and stress are deeply intertwined with the development of these conditions.

It is also important to address the common misconception that psychosomatic illnesses are merely psychological in nature or "all in the head." In reality, the physical symptoms associated with these disorders are real, and they require timely medical treatment, just like any other physical illness. Unfortunately, the complexity of psychosomatic conditions often leads to delays in diagnosis and treatment, causing prolonged suffering for patients who may not receive the medical care they need.

While this study focused on the role of anxiety in psychosomatic illness, we recognize that anxiety is just one of many emotional factors that can influence an individual's health. Strong emotions like anger, fear, and feelings of low self-esteem likely play significant roles as well. We propose that future research should delve into the influence of these emotions to provide a more comprehensive understanding of how emotional states contribute to psychosomatic disorders.

In conclusion, anxiety plays an essential role in the development and manifestation of psychosomatic illnesses. Our findings align with existing literature, confirming that anxiety, along with other emotional stressors, significantly impacts both mental and physical health. This understanding underscores the importance of timely and holistic interventions to address both the emotional and physical components of these complex conditions.

Credit Authorship Contribution Statement

Roxana-Petruța GOGA-VIGARU conceptualized the research study, developed the theoretical framework, and designed the methodological approach. She conducted the literature review and synthesized key theories on anxiety and psychosomatic disorders. GOGA-VIGARU, R. P was also responsible for data collection through the administration of questionnaires, as well as for the analysis and interpretation of the data.

Conflict of Interest Statement

The author declares that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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