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1 Introduction

The word 'psycho-somatic' is needed because no simple word exists which is appropriate in description of certain clinical states.

(Winnicott, 1989, p. 103)

A mother's confidence and care in holding and handling her baby will convey a sense of unity of being and so facilitate an integration of mind with body: this allows a healthy development of emotional expression, so that feelings can be experienced as safe and meaningful. This book is about the ways in which such a state of affairs may be disturbed and later disrupted, causing such unity between mind and body to be challenged. It describes the mental and psychophysiological mechanisms that then result in the emergence of psychosomatic symptoms.

We know from subjective experience¹ that we have a mind and a body: although in health these are mostly felt to exist in some sort of unity and we feel we live inside our bodies, there are times when we experience them as separate entities. For example, in dissociative disorders such as **depersonalization**, the feeling of not quite belonging to one's body can result in a sense of painful unreality. In those clinical states we refer to as psychosomatic disorders, there may also be dissociation between mind and body, although it is **unconscious**. In some individuals, when their minds are too overwhelmed by emotions to handle them adequately, let alone be aware of them, their bodies produce, directly or indirectly, physical symptoms or illnesses: these physical manifestations are considered by the patient and sometimes their doctors to be the main problem. The following story illustrates this.

Case Study

A young man developed strange stabbing pains in his right cheek shortly after he had been to the dentist for a filling.

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He attributed these unpleasant pains to the dental treatment he had received, and over the next two years he underwent numerous dental, anaesthetic and neurological treatments, all of which were to no avail. In the end he was referred to a psychotherapy clinic in our hospital where he was first seen by a medical student. He told her about how he had grown up in an unemotional family where he was picked on by his father, a policeman. At school he had been bullied by other boys for being effeminate. He realized early on that he was sexually interested in other boys, but felt intensely ashamed of this and could never bring himself to tell his parents about it. When as an adult he eventually found the courage to tell them, he was shocked and angered by their reaction. It was not long after this that he developed his atypical facial pains.

After telling the student his story he and the student were astonished to find that his pains had disappeared. They both could now see that his troubled emotions were contributing significantly to his physical symptoms. Being listened to in this way by a warm and caring person had temporarily allowed his symptoms to vanish. He was on the verge of tears but because of his tendency to suppress his feelings he could not cry. He realized how much he needed to go on talking to someone about his life and childhood if he was ever to change his symptoms, which were psychosomatic. Shortly after this he began psychotherapy.

The Romantics (for example, Coleridge and Heinroth) invented the word ‘psychosomatic’ to describe certain physical conditions that they felt required an emotional as well as a physical explanation. Theirs was a reaction to the prevailing scientific materialism of the early 19th-century doctors, whose discoveries had revolutionized clinical practice and the medical understanding of illness, by means of new knowledge about **morbid anatomy** (Foucault, 1973). However, it was not until the end of the 19th century that through the work of Charcot, Breuer and Freud we gained some understanding of how the mind could influence the body. It was through their discoveries about one particular psychosomatic condition, **conversion disorder** (referred to as ‘conversion hysteria’ at that time), and through Freud’s conception of the workings of the unconscious

mind that this understanding was effected. The following chapters are about psychosomatic conditions and the scope for psychotherapy in helping individuals overcome them.

Our emotions and thoughts are in a continuous interaction with our bodies. We blush with shame, we sweat and tremble with anxiety, we become sleepless, tired and fatigued easily in depression. Likewise, our hearts beat more rapidly and we feel a greater sense of physical energy when we are excited. Under certain circumstances we feel a mental detachment from our body: this is often a problem for **schizoid personalities**. Under other circumstances, for example, when experiencing chronic severe physical pain, we may feel preoccupied with our body to the point of mental exhaustion. In severe and potentially lethal physical illnesses, such preoccupation includes intense fear, as well as sadness and depressing thoughts, about the imminent threat of death.

Some physical illnesses, through their effects on the brain, produce major emotional disturbances and alterations in thinking and even consciousness. Our endocrine system, for example, can influence emotions, so that if the thyroid is over-active the increased levels of **thyroid** hormone will make one feel tense. Conversely, if the thyroid is under-active, there is likely to be depression secondary to changes in cerebral metabolism (Lishman, 1978, p.596 and p.607). In over-activity of the **adrenal cortex**, a patient may become depressed or manic when there are major changes in the levels of corticosteroids. The same is true when a patient needs to take a steroid as a drug for treatment of chronic bronchial asthma or for chronic rheumatoid arthritis. In another example, the memory may be severely affected by certain vitamin deficiencies, such as the deficiency of vitamin B6 in alcoholism.

In major mental illnesses such as depression or anxiety there are profound changes in body function. In a severe depression, patients often neglect to take care of themselves. They have interrupted sleep, wake early in the morning, and are tired and easily fatigued; they lack energy and **libido**. In addition, there may be constipation and loss of appetite, with consequent weight loss. In a woman, there may also be loss or alteration of menstruation. In anxiety, there are generalized signs of arousal of the **autonomic nervous system**, so that the pupils are widely

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dilated, accompanied by sweating and tremor of the hands. The mouth is dry and there may be nausea, vomiting and diarrhoea. There is an increased pulse rate, and palpitations may be experienced. There is difficulty in getting off to sleep and a feeling of tiredness.

As can be seen from the above examples, in both health and disease there is a vital interaction between mind and body, and we are constantly being made aware of our own and our patients' psychosomatic existence. Although psychosomatic medicine is concerned with understanding the influence of mental events and emotions on the body, we know that, in reality, this is part of a two-way process, not least because each psychosomatic condition may evoke the same anxiety and fear as other physical illnesses. Patients can feel stigmatised by a diagnosis of a psychosomatic illness, feeling in effect that they are being told that they are making up or imagining their symptoms when, in reality, nothing could be further from the truth. Also, if such a diagnosis leads to them being referred to specialists in psychological treatments, they may feel rejected or abandoned by their doctor.

Many psychosomatic conditions are not purely psychosomatic: a backache started by poor physical posture, and which has interacted with changes in the structure of the vertebral column from arthritis, leading to local and possibly referred pain, may be affected by a pre-existing depression or anxiety, making the whole condition worse. So new symptoms of pain may be produced by this added emotional disturbance. These may lead to fear, resignation and helplessness, and possibly lead to **secondary gain** (the development of a sick role/illness behaviour) with a complex interaction between the patient, the carers and the environment.

There are also **unconscious** factors (Winnicott, 1989) that maintain a psychosomatic symptom, which make a patient resistant to acknowledging the role of his emotions in producing or exacerbating his symptoms. Such resistance has to be respected by a psychotherapist at the outset of therapy, where there may be the additional fear of dependence on a single person (i.e., the psychotherapist). Winnicott (1989) and Balint (1964) both observed that these patients often acquire a vast array of specialists who take care of them in different ways, so developing multiple dependencies. These dependencies may reflect the

significant **splitting** in the unconscious of the patient, and protect him from becoming too dependent on one person alone.

There are a number of psychobiological systems in which brain and body interact, including the central nervous system, the autonomic nervous system, the endocrine systems and the immune system. With each system there are not only the effects of the brain on the body but also complex feedback loops, giving the brain information about the state of each internal organ and tissue and the effects of its regulation on them (see Chapter 4). These psychobiological systems are influenced by our emotional state, which is, in turn, influenced by unconscious as well as conscious factors.

Freud saw in the physical deficits of conversion disorder (formerly called 'conversion hysteria') how each physical symptom might be understood as a symbolic representation, in physical language, of an underlying unresolved unconscious conflict. This conflict was in danger of causing painful emotions which the patient had to deny, **repress** and then convert into the symbolic form as a physical symptom that mimicked a voluntary sensory or motor nervous system deficit. The resolution of the conflict was a compromise which allowed the painful emotions not to be felt.

Case Study

A daughter dealing with the fear of her unresolved hostility towards her mother, who had recently died and whom she had previously looked after when the mother had a paralysed leg caused by a stroke, in her grief developed weakness in the same limb as the mother, instead of facing the pain of her ambivalent feelings towards the dead mother.

Freud realized that such conflicts belonged mainly to childhood, when he discovered that many of his patients had been sexually abused in childhood² which, at the time, had aroused fear, guilt, excitement and humiliation, but which had subsequently been **repressed** and forgotten. These conflicts had been reawoken by a new conflict in the present that had provoked memories from the past, causing the conversion symptom to

occur. We still see conversion disorder in neurological and medical clinics and in patients suffering from post-traumatic stress disorders, such as those who have been in war zones (see Chapter 5, 'Somatization').

Freud, in making these links between unconscious conflicts and body language in conversion disorder, led his medical colleagues, especially the German physician George Groddeck (Groddeck, 1977), to speculate that other stress-related physical conditions had symbolic meaning rendering them responsive to a combination of psychoanalysis and medicine. Later, the American psychoanalyst and physician Flanders Dunbar argued that the vulnerability of personality in a patient with a certain physical condition might contribute to the cause of the condition by means of psychological mechanisms other than conversion. This led to the development of the Chicago School of Psychoanalysis, whose members argued that specific personalities were associated with specific psychosomatic illnesses (Alexander, French and Pollock, 1968) (see Chapter 2, 'Historical Outline').

We no longer regard the personality as so specific for a particular disease but consider that in some psychosomatic conditions certain psychological precipitants have interacted with various non-specific vulnerabilities in a personality to produce illness. This is because emotional processing and regulation by the brain are affected, leading to changes in the body which then precipitate or even contribute to the cause of an illness or change in function (see Chapter 3, 'The Scope for Psychotherapy in Psychosomatic Disorders').

Definition of Psychosomatic Illness

A psychosomatic illness can be defined as any physical illness in which psychological factors have played a significant role in its precipitation and maintenance and, in certain cases, in its causation as well. In practice, the psychological factors are rarely the sole or even the dominant ones, except in the case of eating disorders, conversion disorder, hypochondriasis and body dysmorphic disorder. Psychological factors are often only one of a group of many other factors, including genetic, immune and

environmental factors (e.g., infections) and, as yet unknown, physical factors leading to the onset and maintenance of a condition. Whilst psychological factors, such as bereavement, may act as a precipitant to the illness, they cannot in themselves be considered to be the cause.

Types of Psychosomatic Illness

The commonest psychosomatic illnesses are the functional disturbances of the body in which disordered physiology has led to physical symptoms: here there is no structural pathology (i.e., no damage to the tissues of the body). These are often called *somatizations* or the *somatoform disorders*. They account for up to 30 per cent of all medical outpatient attendances. Some fit into clear diagnostic classifications, such as conversion disorder (formerly called conversion hysteria), somatization disorder, body dysmorphic disorder (formerly called dysmorphophobia), hypochondriasis, irritable bowel syndrome, pruritus (itching), chronic fatigue syndrome, dysmenorrhoea and tension headache. However, many other somatizations elude precise classification and may be fleeting in duration and not so distinct in their presentation. I have considered many of the diagnostic groups of somatization in Chapter 5. Wherever they represent a functional disorder of a particular bodily system, I have considered them under the relevant chapter heading relating to that part of the body (i.e., Chapters 8–14).

Less common but more life-threatening are eating disorders where the outcome is weight restriction, culminating in the rare anorexia nervosa or the commoner bulimia nervosa. In these conditions there are significant risks to health and well-being; with anorexia nervosa there is also a high risk of suicide (higher than for any other psychiatric condition). Here there is significant weight loss produced by self-starvation caused by a morbid fear of being fat. In bulimia nervosa, the patient resorts to compulsive bingeing and vomiting and, although there may be no significant weight loss, the patient may be in danger of significant metabolic disorders. In psychogenic obesity the patient has put on a significant amount of weight, endangering health and life-expectancy as well as causing embarrassment about

appearance to the extent of not engaging in normal social activities. These disorders are considered in Chapters 6 and 7.

Less well understood are the structural disorders in which stress has in some way interacted with vulnerabilities in the individual's personality so as to cause brain–body interactions that damage tissues in the body: these tissues may themselves already be vulnerable for other reasons (e.g., genetic). Here there is both a structural (tissue change) and a functional (physiological change) pathology. The different psychosomatic hypotheses about these conditions remain controversial: physicians and psychotherapists have traditionally been at odds about the relative significance of psychological factors in these conditions and the potential relevance of personality vulnerability in causing them. This is because they have a multifactorial aetiology (i.e., causation) which may include genetic, immune and environmental physical factors as well as psychological factors; the relative significance of any one of these factors may vary from individual to individual (e.g., in inflammatory bowel disease; see Chapter 8) or according to different stages of the life-cycle (e.g., in chronic bronchial asthma; see Chapter 11).

The psychological factors themselves are complex and still mostly unknown; they involve a chain of interactions between externally stressful life situations (such as a loss or the threat of a loss, i.e., a life-event), with an emotional vulnerability in a physically susceptible individual. The consequent emotional disturbance, possibly a dysregulation of emotions (Taylor, 1987), causes changes in the brain–body regulatory systems, e.g., autonomic, neuro–endocrine and neuro-immune (see Chapter 4). These systems can affect a vulnerable target organ at a cellular or metabolic level, e.g., the colonic **mucosal cell** in ulcerative colitis, or the bronchial mucosal and smooth muscle cells in bronchial asthma, to produce physical symptoms (abdominal pains, with altered bowel movements and sometimes rectal bleeding in ulcerative colitis, and **bronchospasm** with breathlessness and wheezing in bronchial asthma, respectively).

The degree to which psychological factors have an influence in these conditions is also very variable as, for example, with ulcerative colitis and asthma. This has led to misunderstandings by some doctors about the role of psychosomatic factors. So far, in only one structural disorder have psychological

factors been scientifically proven to be a cause of structural pathology: this is in post-traumatic stress disorder where there is good evidence that, if the stressful situation is sufficiently prolonged, lasting damage to the hippocampus in the brain ensues (Sapolsky, 2003).

Nevertheless, in those conditions that have been most extensively researched, there does seem to be clear evidence of a significant role for stress and life-events as triggers of physical pathology in particular organs or bodily systems, such as in eczema, neurodermatitis, urticaria, chronic peptic ulceration, inflammatory bowel disease (ulcerative colitis and Crohn's disease), bronchial asthma, coronary artery disease and essential hypertension. The evidence for psychogenicity and the role of various psychological treatments is reviewed in Chapters 8–14 (i.e., under the relevant bodily system).

Often, doctors' unwillingness to consider the psychological factors in potentially psychosomatic structural illnesses leads to a collusion with their patients' futile and sometimes self-destructive search for a purely physical solution. The management of psychosomatic patients requires careful cooperation between the general practitioner, the medical specialist and the psychotherapist. In this way a patient can receive adequate physical as well as psychological treatment; both are needed in the effective management of these conditions

When we explore the possible significance of psychological events (life-events) in the genesis of any psychosomatic disorder, we must try to distinguish between those events that may have precipitated an illness and those which are likely to be causal. Life-events research (Miller, 1989) helps to make such distinctions which may be difficult to discern from retrospective case material gleaned from psychotherapy.

Psychosomatics has a rich history which is considered specifically in Chapter 2. This is followed by a summary of contemporary psychoanalytic views about the management and treatment of psychosomatic disorders (see Chapter 3).³ This chapter may require cross-reference to the chapters on individual psychosomatic disorders, as well as to the chapter on stress and the body (Chapter 4) which discusses how psychologically stressful life events interact with the brain to produce psychobiological changes in the body. There has been so much

misunderstanding about the role of psychological factors in cancer that I have devoted a separate chapter to this (Chapter 15).

In each of these chapters on individual psychosomatic disorders I describe their natural history, their clinical presentation, their aetiology, including the theories and evidence for a psychological contribution to their causation, as well as reviewing the efficacy of psychological and physical treatments.

Psychosomatic medicine is an exciting and rewarding part of medicine and psychotherapy because it offers the possibility of bringing the mind and the body together in ways that can help certain patients recover from distressing and disabling conditions. Much of the work of psychotherapists threatens them with too great an emphasis on the mind, just as the physician's work can present him or her with too great an emphasis on the body. Psychotherapy and medicine need to find ways to integrate the *psyche* with the *soma* and to work together if they are to achieve a greater understanding and treatment of psychosomatic conditions. To achieve this, it is necessary that doctors and psychotherapists adopt a *psychosomatic* approach to all illness. This book is about the uses of psychotherapy in psychosomatic disorders and how a psychotherapeutic imagination can inform a psychosomatic approach to illness.

We need to help future generations of doctors develop an interest in this subject and find a psychosomatic approach to all their patients. I describe some ways that may be achieved in Chapter 16.

Further Reading

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