20
Psycho-Somatic Disorder

I. Psycho-Somatic Illness in Its Positive and Negative Aspects

Originally a lecture given to the Society for Psycho-Somatic Research, 21 May 1964[1]

Preview

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

2. The hyphen both joins and separates the two aspects of medical practice which are constantly under review in any discussion of this theme.

3. The word accurately describes something that is inherent in this work.

4. The psycho-somatist prides himself on his capacity to ride two horses, one foot on each of the two saddles, with both reins in his deft hands.

5. Some agent has to be found that tends to separate the two aspects of psycho-somatic disorder, to give the hyphen a place.

6. This agent is, in fact, a dissociation in the patient.

7. The illness in psycho-somatic disorder is not the clinical state expressed in terms of somatic pathology or pathological functioning (colitis, asthma, chronic eczema). It is the persistence of a split in the patient's ego-organisation, or of multiple dissociations, that constitutes the true illness.

8. This illness state in the patient is itself a defence organisation with very powerful determinants, and for this reason it is very common for well-meaning and well-informed and even exceptionally well-equipped doctors to fail in their efforts to cure patients with psycho-somatic disorder.

1. Published in its present form in the *International Journal of Psycho-Analysis* (1966). Copyright © Institute of Psycho-Analysis.

9. If the reasons for this tendency to fail are not understood, medical practitioners lose heart. Then the subject of psycho-somatics becomes a subject for non-clinical or *theoretical* survey, and this is relatively easy because the theoretician is detached, and is not cluttered up by responsibility for actual patients. The theoretician is the very one who is apt to lose touch with the dissociation, and he is able to see from both sides only too easily.

I have a desire to make it plain that *the forces at work in the patient are tremendously strong*. The dilemma of the practising psycho-somatist is indeed a reality.

One or two complications should be mentioned at this stage in the argument:

a. Some practising doctors are not really able to ride the two horses. They sit in one saddle and lead the other horse by the bridle or lose touch with it. After all, why should doctors be more healthy in a psychiatric sense than their patients? They have not been selected on a psychiatric basis. The doctor's own dissociations need to be considered along with the dissociations in the personalities of the patients.

b. Patients can have more than one illness. A man with a coronary spasm tendency, secondary to emotional confusion, may also have calcified arteries, or a woman with fibroids and menorrhagia may also have a sexual immaturity. And so on. On the whole it is the hypochondriacs who fail to get examined when they have cancer of the breast or a hypernephroma, and it is the patients who are physically ill who put themselves forward as needing psycho-analysis or hypnotism. And patients who are always pestering a succession of doctors to examine them very seldom have anything to be discovered by physical test. In this way doctors get led astray, and amazing stories of neglect are told, some of which one must believe.

c. Many patients do not split their medical care into two; the split is into many fragments, and as doctors we find ourselves acting in the role of one of these fragments. I have (1958) used the term "scatter of responsible agents"[2] to describe this tendency. Such patients provide the examples quoted in social casework surveys in which twenty or thirty or more agencies have been found to have been involved in relief of one family's distress. Patients with multiple dissociations also exploit the natural splits in the medical profession such as:

2. See Winnicott's review of Michael Balint's *The Doctor, His Patient and the Illness* (1958), in Chapter 52 of this volume.

- medical
- surgical
- psychiatric
- psycho-analytic
- psychotherapeutic
- homeopathic
- osteopathic
- faith-healing

various ancillary services

Psycho-Somatics as a Subject

Psycho-somatics is in many ways a curious subject, for if one ascends into the sphere of intellectualisation and loses contact with the actual patient, one soon finds that the term psycho-somatics loses its integrative function. One soon asks oneself, why is there this speciality? Does it not concern every aspect of human growth, except perhaps that of behaviour? I find myself involved in the same considerations that I tried to clarify for my own benefit in "Mind and Its Relation to the Psyche-Soma" (1949),[3] because it was in the writing of that paper that I became aware of the confusion that exists through the use of the term "mental disorder," a term that somehow fails to cover the case of a child with a bilious attack, or the case of a person with a fatal physical disease who does not become devoid of hope.

I suggest that any intellectualised attempt to make psycho-somatics easy keeps clear of the very clinical clutter-up which bogs us down in our actual work. We find ourselves involved in attempts to build a *theory* where the word should be *theories* (in the plural). My aim is not to state a final truth, but to make my point, and so to provide material for consideration.

The element that gives our work on psycho-somatics cohesion, as I have stated, seems to me to be the patient's pathological splitting of the environmental provision. The split is certainly one that separates off physical care from intellectual understanding; more important, it separates psyche-care from soma-care.

If I take a case in my practice now and try to describe the dilemma, I run the risk of ruining my treatment, because however carefully I word what I have to report I cannot satisfy my patient, who might

3. In *Collected Papers: Through Paediatrics to Psycho-Analysis* (London: Tavistock, 1958; New York: Basic Books, 1975; London: Hogarth Press, 1975).

read what is reported. The solution in the case of any one patient is not to be sought in a more and more careful reporting; the solution can only come through the success of the treatment which, if time be allowed, may result in the patient's becoming able to need no longer the split which creates the medical dilemma which I am describing. As I am in practice I need to be very careful in presenting my illustrative material.

Let us pretend that I have a patient among the readers, a patient with a variety of this disorder that we label psycho-somatic. The patient will probably not mind being quoted, that is not the trouble here. The trouble is that *it would not be possible for me to give an acceptable account of something that has not yet become acceptable in that patient's internal economy.* Only the continuation of the treatment is of use in the actual case, and in the course of time the patient whose existence I am postulating may come to relieve me of the dilemma that his illness places me in, the dilemma that is the subject of my paper. And one thing I would hate to do would be to seduce the patient to an agreed statement which would involve an abandonment of the psyche-soma and a flight into intellectual collusion.

Am I beginning to convey my meaning that *in practice* there does exist a real and insuperable difficulty, the dissociation in the patient which, as an organised defence, keeps separate the somatic dysfunction and the conflict in the psyche? Given time and favourable circumstances the patient will tend to recover from the dissociation. Integrative forces in the patient tend to make the patient abandon the defence. I must try to make a statement that avoids the dilemma.

It will be evident that I am making a distinction between the true psycho-somatic case and the almost universal clinical problem of functional involvement in emotional processes and mental conflicts. I do not necessarily call my patient whose dysmenorrhoea is related to anal components in the genital organisation a psycho-somatic case, nor the man who must micturate urgently in certain circumstances. This is just life, and living. But my patient who claims that his slipped disc is due to a draught might claim to be labelled psycho-somatic, and so qualify for our attention in this paper.

Illustrative Material

When I reach for clinical examples, I am of course overwhelmed by a mass of material. There must be a hundred ways of proceeding from this place in my exposition of my point of view.

Case of Anorexia Nervosa

There are certain common features in anorexia cases, though in one case the child may be almost normal and in another she (sometimes he) may be very ill. One child may nearly die of starvation in a phase-disturbance, and yet recover spontaneously, and in another less dangerous example the child may remain a psychiatric casualty.

I describe briefly a girl of ten years who is in analysis. She is physically well because she is taking food as a medicine. She eats nothing at all as food. You can imagine that this girl is very suspicious of talk between her physical doctors and her analyst. At the same time she absolutely and consciously relies on a close co-operation between the analyst and the doctors and the nursing staff. There are multiple splits; nurses and doctors are classified by the patient into those who understand and those who could never understand. Every effort is made by all concerned to avoid the moment when logic appears on the scene and makes plain the existence of the dissociation in the patient. The worst possible thing would be to force this issue. One doctor said to her: "You are wasting your time, you must do school lessons." This produced a threat of anxiety of extreme intensity, and the situation was only saved by the fact that the analytic session came soon after this dangerous event. The patient knew she could rely on the analyst to forbid teaching. But I did not need to do anything because she soon found one of the other doctors, "the one who understands," and he of course proscribed teaching and put the whole matter straight. One of the ward nurses, however, and one of the ward charwomen, could be relied on to say something tactless, that is to say, something that ignored the dissociation in the patient. I do believe that by now no-one within ten miles of this girl would actually tell her to *eat,* so well has her very great need to be left alone in this respect become known and reluctantly accepted.

Here is another way of describing this aspect of this case. For many months in this analysis the patient's sensations and agonies and dreams appeared in the form of urgent material related to the belly. There was a whole world of objects in and falling out of her front. In a dream there were filing cabinets and even steel doors with sharp edges that gave her acute belly pain. These could not be altered by interpretations relative to internal objects. One day (after years) she reported a *headache.* Here at last was a shift from the dissociated state since headache could be accepted as associated with a confusion of ideas and of responsibilities. I now interpreted that she was telling

me about an illness of her *mind,* and I therefore slipped over from being part of a psycho-somatic team into the role of psychotherapist. This has persisted, and for many months now there has been hardly any report to me in terms of belly stuff. Now, as a mental patient, she is able to give me material that I can interpret in inner object terminology, if I feel so disposed, and I can work with the patient on the nature of her fantasy of her inside, and what is there to be found, and how it got there, and what to do with it. In the previous phase, by contrast, there was a flight to delusional belly-symptoms, and a denial of mind content.

If this patient were here now, reading this paper, she would find herself ill at ease, because she would realise that the doctors who look after her are her analyst's friends. Psycho-somatic patients are always complaining that the various doctors do not co-operate, but they become anxious when in fact they do meet to discuss the case. Mercifully, my paediatric colleagues are not wholly committed to this point of view of the dynamic psychologist or of the psycho-analyst, and so there is some split actually present in the medical environment; this makes the child feel she has allies whichever side she happens to be on in her internal conflict arising out of the dissociation.[4]

In the practice of psycho-somatics what the psychotherapist needs is the co-operation of a *not too scientific* physical doctor. This sounds very bad, and I expect opposition when I make this claim. Yet I must state what I feel. When doing the analysis of a psycho-somatic case I would like my opposite number to be *a scientist on holiday from science.* What is needed is science-fiction rather than a rigid and compulsive application of medical theory on the basis of perception of objective reality.

An Adult Patient

A psycho-analytic patient of mine, a woman in mid-life, has depended on many beside her analyst in the course of her treatment. Let me list a few:

The family G.P. and a group of gynaecologists and pathologists.

Her osteopath.

4. 1965–66. Since this was written in 1964 the nature of this patient's illness has altered. She is now not a psycho-somatic case. She has a severe disturbance of emotional development and she is using the analysis for the relief of mental conflict and agony, without employing the psycho-somatic defence. (Later note: this patient has done well.)—D.W.W.

Her dermatologist.
Her former analysts.
Her masseuse.
Her hairdresser, especially the *other* one who cures her occasional alopoecia without charge.
A spiritualist with clairvoyance.
The special parson.
The nannie of her children, very carefully chosen to be good enough in the care of infants and therefore capable of turning into a mental nurse for herself.
The very special garage for her car.
Etc.

Here is a "scatter of responsible agents" secondary to an active disintegration in the economy of the patient's personality. Integration in her analysis has been a gradual undoing of the organised scatter of therapeutic agents and the multiple dissociation of her personality by which she defended herself against loss of identity in a merging in with her mother. Is it clear that initially the patient used all these helpers in a dissociated way? There was a flitting from one to every other, and as there was an essential multiple dissociation the patient was never all at once in one place and in touch with each and every aspect of the care that she organised.

But in the course of the treatment a very big change occurred. I have watched all these agents gradually settle down to being *aspects of the transference.* When the patient was near to this achievement she was able for the first time to love someone, her husband. The personality splitting was related to a need the patient had to rescue a personal identity and to avoid merging in with the mother. It was a red-letter day for me when the patient rang me up by mistake when intending to ring her butcher.[5]

A Case of Colitis

In a third case, a less happy outcome can be reported to balance this. A child was having analysis by me because of colitis, certainly a good example of the type of disorder that appears along with the split that I am trying to describe. Unfortunately I was unable to see early

5. In case this patient should read these words I would wish to state that this description is not only inadequate in every way, it is not even accurate. But I am using it to illustrate an idea. (Later note: this patient has done well.)—D.W.W.

enough that the ill person in this case was the mother. It was the mother who had the essential split, and the child who had the colitis. But it was the child who was brought to me for treatment.

I was doing very well with the child and I thought I had the mother's co-operation. I certainly had her friendliness. When the girl was eight years old I said she could go to school, as she wished to do so, and this produced a change in the mother's unconscious attitude. The child got to school but soon became very ill indeed.

I now found that it was at eight years that the mother had herself been a school-refusal case, and certainly this in turn had to do with her own mother's psychopathology. The mother, though unconscious of the fact, could not allow her daughter, who was living her life for her again, to go outside the pattern.

After the unexpected breakdown of my treatment I found that the child was under several general practitioners, and also in the care of a paediatrician, and also, at one time towards the end of my ministration, was attending a hypnotist and another psychotherapist. It was not long before she had her colon removed by a surgeon, and I dropped out of the case, my going being scarcely noticed. I was not even dismissed. Yet three months earlier I had the whole case in my hands, as it seemed, and I thought I had the full confidence of the family, and I certainly had the confidence of the child in so far as she was an autonomous human being. Unfortunately, this was precisely what she was not.

I do not know the outcome and I have not the heart to enquire. My error was to treat the child when the illness was in the mother, and the illness included the essential psycho-somatic dissociation that is the subject of this paper. Not that I neglected the mother's psychopathology, which the child knew about, and which was all the time an important element in the work done between the child and myself. But I had forgotten the tremendously powerful unconscious need that exists in such a mother to scatter the responsible agents and to maintain the *status quo* of which, here, the child's somatic illness was an integral part. The mother could have a healthy body while the illness was in the child.

Recapitulation

A multiplication of clinical examples would not further the argument. There is no area of personality development that escapes being in-

volved in a study of psycho-somatic disorder. A severe disintegration threat can be hidden in a cricked neck; an insignificant skin rash may hide a depersonalisation; blushing may be all that shows of an infantile failure to establish a human relationship through the passing of water, perhaps because no-one would look and admire in the phase of micturition potency. Moreover suicide may be gathered into a hard patch on the inner maleolus, produced and maintained by constant kicking; delusions of persecution may be confined clinically to the wearing of dark glasses or a screwing up of the eyes; an antisocial tendency belonging to a serious deprivation may show as simple bed-wetting; indifference to crippling or painful disease may be a relief from a sado-masochistic sexual organisation; chronic hypertension may be the clinical equivalent of a psycho-neurotic anxiety state or of a long-continued traumatic factor, such as a parent who is loved but who is a psychiatric casualty. And so one might go on, but all this is familiar ground.

My contention is that *these things do not of themselves constitute psycho-somatic disorder,* nor do they justify the use of a special term or the organisation of a *Psycho-Somatic Group* within the general medical and surgical profession. What makes sense of this grouping is the need that some patients have to keep the doctors on two or more sides of a fence, because of an inner need; also that this inner need is part of a highly organised and powerfully maintained defensive system, the defences being against the dangers that arise out of integration and out of the achievement of a unified personality. These patients need us to be split up (yet essentially united in the far background that they cannot allow themselves to know about).

For a long time I have been puzzled by our failures to classify psycho-somatic disorders and our inability to state a theory, a unified theory of this illness group. When I found a way of saying to myself what psycho-somatic disorder really is I found myself with a ready-made classification which I will give (for what it is worth). But first let me re-state my main thesis, linking it with the theory of maturation in individual growth.

The Positive Element in the Psycho-Somatic Defence

Psycho-somatic illness is the negative of a positive; the positive being the tendency towards integration in several of its meanings and in-

cluding what I have referred to (1963)[6] as personalisation. The positive is the inherited tendency of each individual to achieve a unity of the psyche and the soma, an experiential identity of the spirit or psyche and the totality of physical functioning. A tendency takes the infant and child towards a functioning body on which and out of which there develops a functioning personality, complete with defences against anxiety of all degrees and kinds. In other words, as Freud said many decades ago, the ego is based on a body ego. Freud might have gone on to say that *in health* the self retains this seeming identity with the body and its functioning. (The whole complex theory of introjection and projection, as well as conceptualisation around the term "internal object," is a development of this theme.)

This stage in the integrating process is one that might be called the "I AM" stage (Winnicott, 1965).[7] I like this name because it reminds me of the evolution of the idea of monotheism and of the designation of God as the "Great I AM." In terms of childhood play this stage is celebrated (though at a later age than I have in mind now) by the game "I'm the king of the castle—you're the dirty rascal." It is the meaning of "I" and "I am" that is altered by the psycho-somatic dissociation.

The splitting of the psyche from the soma is a retrogressive phenomenon employing archaic residues in the setting up of a defence organisation. By contrast the tendency towards psycho-somatic integration is a part of forward movement in the developmental process. "Splitting" is here the representative of "repression" that is the appropriate term in a more sophisticated organisation.

Classification

If this be true then it should be possible to classify psycho-somatic illness according to the theory of the maturational processes, including two main ideas:

1. A primary unintegrated state, with a tendency towards integration. Result dependent on

   Mother's ego reinforcement, based on her adapting capacity, giving the infant's ego a reality in dependence.

6. "The Mentally Ill in Your Caseload," in *The Maturational Processes and the Facilitating Environment* (London: Hogarth Press, 1965).

7. Various chapters in *The Maturational Processes and the Facilitating Environment* and *The Family and Individual Development* (London: Tavistock, 1965).

Maternal failure which leaves the infant without the essentials for the operation of the maturational processes.

2. Psycho-somatic integration or the achievement of the "indwelling" of the psyche in the soma, and this to be followed by the enjoyment of a psycho-somatic unity in experience.

In the process of integration the infant (in healthy development) gains a foothold in the "I AM" or the "king of the castle" position in emotional development, and then not only does the enjoyment of body functioning reinforce ego development, but also ego development reinforces body functioning (influences muscle tone, coordination, adaptation to temperature change, etc., etc.). Developmental failure in these respects results in uncertainty of "indwelling," or leads to depersonalisation in so far as indwelling has become a feature that can be lost. The term indwelling is used here to describe the dwelling of the psyche in the personal soma, or *vice versa*.

At the "I AM," or "king of the castle" position the individual may or may not for internal or for external reasons (and the infant is still highly dependent) be able to cope with the rivalry that this engenders ("you're the dirty[8] rascal"). In health rivalry becomes an added stimulus to growth and to the zest for living.

Hence, psycho-somatic disorder relates to

Weak ego (dependent largely on not good-enough mothering) with a feeble establishment of indwelling in personal development;

and/or

Retreat from I AM and from the world made hostile by the individual's repudiation of the NOT-ME, to a special form of splitting which is in the mind but which is along psycho-somatic lines.

(Here an actual persecuting environmental detail may determine the individual's retreat to some form of splitting.)

In this way, psycho-somatic illness implies a split in the individual's personality, with weakness of the linkage between psyche and soma, or a split organised in the mind in defence against generalised persecution from the repudiated world. There remains in the individual ill person, however, a tendency *not* altogether to lose the psycho-somatic linkage.

Here, then, is *the positive value of somatic involvement*. The indi-

8. This word here implies: "You are not (as I am) a womb-baby capable of integration and autonomy, but you are an excretory product of your mother, without form or maturational process."—D.W.W.

vidual values the potential psycho-somatic linkage. To understand this one must remember that defence is organised not only in terms of splitting, which protects against annihilation, but also in terms of protection of the psyche-soma from a flight into an intellectualised or a spiritual existence, or into compulsive sexual exploits which would ignore the claims of a psyche that is built and maintained on a basis of somatic functioning.

One more complication. Naturally, when the personality is dissociated, dissociations in the environment are exploited by the individual. An example would be the use made of a tendency in the mother towards disintegration or depersonalisation, of parental discord, or of the break-up of the family unit, or of antagonism (especially unconscious antagonism) between family and school. In the same way, use is made of the splits (to which I have referred) in the matter of medical provision.

Here there can be a return to my main idea, which is that the existence of a "psycho-somatic" or (psycho somatic) group of doctors depends on the patients' need for us to split up for practical purposes, but to remain theoretically united by a common discipline and profession.

Our difficult job is to take a unified view of the patient and of the illness *without seeming to do so in a way that goes ahead of the patient's ability to achieve integration to a unit.* Often, very often, we must be contented to let the patient have it, and to manipulate the symptomatology, in a box-and-cox relation to our opposite numbers, without attempting to cure the real illness, the real illness being the patient's personality split which is organised out of ego weakness and maintained as a defence against the threat of annihilation at the moment of integration.

Psycho-somatic illness, like the antisocial tendency, has this hopeful aspect, that the patient is in touch with the possibility of psycho-somatic unity (or personalisation), and dependence, even though his or her clinical condition actively illustrates the opposite of this through splitting, through various dissociations, through a persistent attempt to split the medical provision, and through omnipotent self care-taking.