

The psychosomatic mosaic

Special Report: *Psychological Medicine*

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'It is the theory that determines what is observed.'

– Einstein

It is, perhaps, a universal wish to find, and relate to, an orderly universe, and yet the advancing edge of science always produces more that is questionable than answered. Medical theory and practice do not escape this principle. Whether it is cancer or the common cold, the mysteries of illness continue to outflank our organizing concepts. We find 'causational agents' – carcinogens or viruses – to explain disease and yet they remain partial explanations. Why does Mr H., who smoked only 15 cigarettes a day develop lung cancer, while his brother who smoked 40 remain clear? Why does Timothy develop a cold and not his four brothers and sisters? The traditional sciences, usually, have no substantial answers to such simple questions.

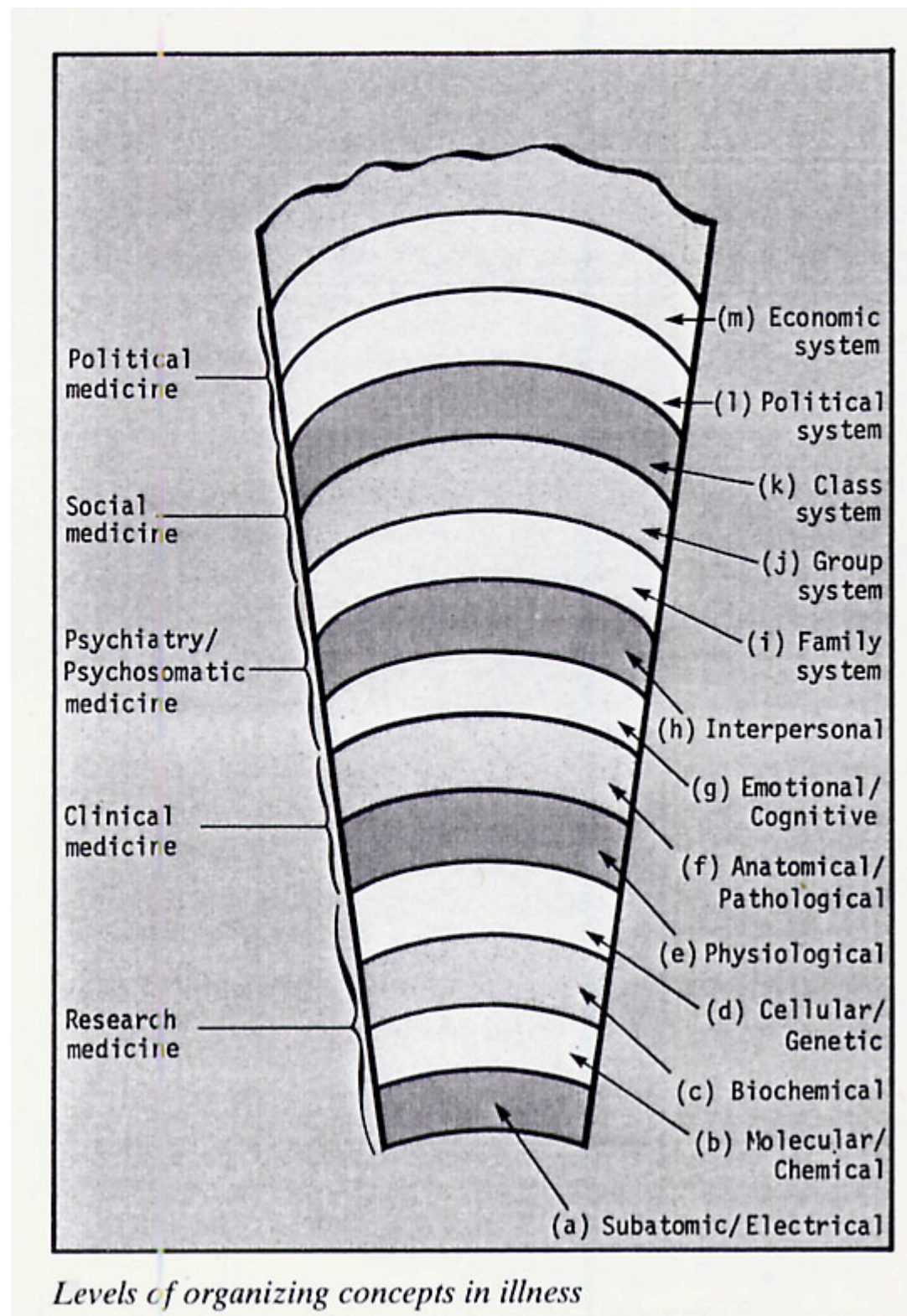
Levels of organizing concepts in illness

The quotation from Einstein is not just a philosophical principle. Our theories determine the configuration, content and outlook not only of scientific activities, but also our *personal* methods of experiencing and responding to the world. In medical practice this leads to professionally self-validating views and models of illness which are confined to the physical and deterministic. Analyses of illness are thus conventionally expressed in terms of anatomy, physiology, chemistry and the like.

There are, however, many other possible levels or approaches to illness, but they do not fit into this traditional mould.

Figure 1 illustrates how we may conceive illness from the level of subatomic physics to political theory.

Figure 1



It is important to note that, although formulations at different levels may be dissimilar, they are not exclusive of one another; they are merely different levels, or angles, of observation and analysis. Much confusion has arisen because of our

tendency to attempt to reduce our diagnostic and therapeutic formulations to only one, or a few, levels of organizing concepts.

Ascribing a man's duodenal ulcer to acid hypersecretion rather than his unresolved and repressed infantile hostility, may thus tell us more of a doctor's inclination, training and frame of reference than of the cause of the patient's illness. Our models derive as much from our psychology, as the world which we are attempting to define or influence.

Lord Kelvin, a once-eminent physicist, remarked 'If it works, it is true', and it is this pragmatic principle which should define the level and manner in which we operate in any particular clinical circumstance. Nevertheless, most doctors operate predominantly at levels (e) and (f), this being largely a reflection of the social definition of their role, and also how they see themselves; the image of potent biological engineer has its roots both in private fantasy and public expectation. Other levels of formulation and intervention thus tend, in practice, to be disregarded, avoided or dismissed, even though at times they may 'work'.

The reasons for this exclusion are both practical and complexly psychological. In practice, doctors often do not have the time, the expertise or the interest to pursue these other levels. Also the patient may neither expect nor want his doctor to perform anything beyond the traditional medical services. Yet deeper psychological issues define the pattern just as much. The doctor's fear of powerful feelings underlying the manifestations of illness, or his wish to exercise command over both his patient and what his patient brings him, are common examples. So, too, is the patient's wish to divorce his physical disturbance from its matrix of internal or relationship conflict; the man whose psoriasis gets worse when his wife goes on holiday alone, might be an example of this.

To illustrate how these principles may be employed in both diagnostic and therapeutic ways, a case history of a young asthmatic girl will be described. The letters in brackets correspond to the levels of organizing concepts in the figure. The ways in which the doctor might focus his attention and organizing concepts at different levels are also illustrated. Because of the author's interest, levels (g), (h), (i)

and (j) are examined in greater detail. Levels (k), (l) and (m) are not considered to be in the scope of this article.

A 'simple' case of childhood asthma

Carol F, aged six years, was seen by her doctor at home because of her increasing wheeziness of one week's duration. This had become more severe, despite the competent use of antispasmodic, and later, antibiotic drugs. By the time of his visit Carol showed signs of marked bronchospasm and respiratory embarrassment ((e), (f)) and Mrs F was both agitated and anxious about her daughter's condition ((g)). Shortly before his home-visit, Dr V received a telephone call from Mr F asking for a visit; the doctor felt Mr F's tone to be unduly threatening and accusatory, as if, somehow, Mr F blamed the doctor for Carol being ill. Dr V bore this with resigned stoicism and, by the time of his visit, had decided that Carol should be admitted to hospital, which he later arranged.

Carol had always been prone to chestiness; as an infant she had frequently been slightly wheezy and catarrhal, and Dr V had repeatedly treated this, with transient benefit, with the usual medicines ((c), (f)). He elicited the fact that Mr F's family had been prone to asthma, as had Mr F as a child, so he thought that Carol's complaint was partly genetic in origin (d). Dr V confirmed this hypothesis when Carol also developed flexural eczema, a sign of 'atopic allergy', thus also showing a hypersensitivity component to her illness. Her increased wheeziness when the pollen-count was high in summer was another manifestation of this (d). In the winter, too, Carol would have more trouble with her breathing and this was thought to be an allergic sequel to infections of her respiratory tract (d). Dr V had noticed how Carol was a 'very good' but quiet and introspective child (g) but he had explored this only so far as to say to Mrs F, 'Do you think Carol is worried about anything?'; to which Mrs F responded by turning to the little girl and asking rhetorically, 'I don't think so, dear. You're not worried, are you?'. Carol, duly hypnotised, nodded a whimsical 'No' to the avuncular Dr V, who asked no more.

Dr V is a practical doctor who has little time to pursue modern thinking of prostaglandin activity or immunological aspects of the globulins in the role of asthma ((b), (c)). He is vaguely aware of the efforts of medical research workers in this area and recently was interested by an article which suggested that changes in the ionosphere

could affect the electrical activity of cell membranes in vivo, thereby precipitating certain types of episodic illness (a). Dr V cannot make any use of these theories in his clinical work, though sometimes he wonders how these facts will be incorporated into future patterns of practice.

Dr V's observations about Carol's compliance and sensitivity were easily made. She is a slight, pale child who looks unduly timid and worried, and talks with submissive reticence. Indeed, in his dealings with her, Dr V had noticed how she rarely spoke for herself, even when perfectly able, her mother quickly interposing herself between Carol and the doctor, and then commandeering the dialogue (h). He thought this might be due, simply, to the effect of her recurrent illness and mother's ensuing anxiety.

Carol developed this attack of asthma, her worst ever, just as she was due to start at primary school; a fact which Carol and her mother were keenly aware of, but which had escaped the notice of Dr V. Had Dr V been attentive to this, he might have correctly supposed that Carol was 'anxious' about this important development in her life (g). And yet Carol's two other siblings, Brian (eight years) and Sue (nine years), never showed anxiety of this kind, so why should Carol?

Parental history

For many years Mrs F had seen Dr V for protean and ill-defined somatic complaints, which had little to suggest structural disease, but which he nevertheless, at first, investigated. Eventually he concluded that Mrs F's complaints were 'functional' in nature. He experienced Mrs F as an anxious, taut and frightened woman, who seemed to radiate a sense of fear, urgency and wanting. In her visits to the doctor she would always refer these feelings back to her presenting physical complaints. On a few occasions Dr V had said something like, 'I can't find anything physically wrong with you. I think it must be your nerves. Is anything in particular upsetting you at the moment?'. At this suggestion she seemed uncomfortable, perhaps affronted, and with a blank look she would shift uneasily in her chair, foreclosing the interview by asking for 'a tonic' or repeat prescription.

Mr F, by contrast, rarely attended the surgery and, when he did, it was usually for a tangible medical complaint which the doctor could quickly and easily deal with. On several occasions, though, he had come with his wife, to amplify her complaint and

underline her conviction that 'something must be wrong, and that Dr V must do something about it (h). At these times the doctor felt pressurised, and usually escaped from the corner into which he was being forced by arranging a hospital referral, which he knew to be unnecessary. Dr V is vaguely aware, therefore, that there may be important tensions in Carol's family which could be contributing to her illness. But within the context of his brief clinical encounters with them, he has been unable to define or use these patterns to either diagnostic or therapeutic advantage.

Let us look in greater detail at the members of Carol's family and the patterns that emerge at levels (g), (h) and (i).

Mrs F had always hoped for different things from her marriage. She herself is illegitimate, and was reared in a variety of institutions and by foster parents. So far as she knows, her own mother became pregnant at the age of 16 years, by an American sailor, at the end of the Second World War. The relationship lasted only a few months and, although the mother had wanted to keep her infant, her own wishes had been swept aside by the wave of her family's shock and indignation. As a child Mrs F was often treated kindly by her caretakers, but she was unable either to understand or predict what was happening to her, and developed a submissive wariness in her attachments.

By the time she was five years old she came to the conclusion that there must be something wrong with her, for her mother and father to have abandoned her. Failing to understand the complex reasons for the fragmented pattern of her care, it seemed to her that any satisfaction of her need for stability and love was sooner or later countered by unaccountable and sudden loss. At first she would openly show her anger and sadness over such losses, but eventually she thought it best to conceal her hurt, initially from other people, but later from her own conscious awareness.

As an adult Mrs F seems to cope 'normally' although, as we have seen, Dr V has noticed her hypochondriasis and tension. But to Mrs F, her life and relationships seem much more tenuous than an outside observer might suppose. Despite her apparent social integration, she describes her life as 'like hanging on to the edge of a cliff'; in her dreams this is reflected by a 'terrible vision of falling into nothingness'. Her relationships are accompanied with much inner anxiety, in which Mrs F has a vague

but ominous sense of imminent catastrophe. Socially, however, she seems merely to be rather tense and circumspect.

Mr F's childhood was very different, yet equally decisive. As the last (and probably accidental) birth in a family of eight children, he had a stable, but harsh, family experiences. By the time he was born, his mother was weary and his father resentful of the added responsibility brought about by his birth. It was not only food and money which were in short supply for the little boy but love, patience and attention. Mr F's father had a bullying and vitriolic streak and, by the time Mr F was a toddler, his father was using the boy as a vent for his frustrations. But Mr F was a resilient child and, rather than succumb to his father's dominance and sadism, he devised precocious strategies of avoidance and independence. As a schoolboy he looked to his friends for support and identification, and at the age of 15 years resolutely left his family for the Merchant Navy.

Some would consider it coincidence that Mrs F married a sailor. Psychoanalytic theory might postulate that she was trying to reclaim the father who had abandoned her. Transactional analytic theory would maintain that she did so to maintain a homeostatic system, where she could repeat the conditioned patterns of her childhood as this, paradoxically, represents security; the world she has experienced and knows how to handle. Whatever the explanatory theory, Mrs F is beset with the same feelings of insecurity and impotent wanting that she experienced as a child. Mr F is a dutiful, though patriarchal, husband and father, a good provider and a source of reliable practical support when at home. But he avoids the finer nuances of trust and closeness, and Mrs F is mute in the face of her need for such emotional nourishment. As she confided once to an interviewing psychologist: 'He's so good really, and he isn't often home; I couldn't really criticise him ... I'd be afraid to rock the boat ...(!)'.

When her children were infants, Mrs F found herself more serene, secure and satisfied than at any other period of her life. She felt a sense of attachment and belonging, which she wished could go on forever. For all their demands and inevitable episodes of difficult behaviour, her babies would continue to want her and love her as a mother. She sensed in herself a streak of resentment and sadness as her two older children became more independent and looked to other adults and children for their sense of belonging. Mrs F did not want to be abandoned with finality, and so Carol, as the youngest child, became

special and precious for her mother; both a repository for her vulnerable feelings and a buffer against her own loneliness and fears of abandonment.

Although Carol had not yet the command of words or concepts to articulate her dilemma, she knew that mother was somehow frail and in need of protection. She sensed a danger in growing apart from mother, as if mother would collapse or stop loving her. Confronted by this wordless threat, Carol complied with what she sensed as her mother's demands. She became a rather clinging child, disinclined to contact with other children. When other children played in the street, Carol would rather keep her mother company indoors.

Her physical illnesses could be seen as a somatic expression of her own, her mother's, and perhaps the whole family's conflicts. Her asthma both reinforced the bond between the child and her mother, and expressed the anger which she felt towards her mother for controlling and burdening her as she did. Carol often felt overwhelmed by what she experienced as her mother's needs, and sometimes in her fantasies, in an effort to be free, she would harm her mother or even make her disappear. Such strong images would usually bring in their wake intense feelings of fear and guilt because of what, in fantasy, she had brought about. Carol's asthma then seemed to her like a containment or punishment. In psychodynamic and interpersonal senses, her illnesses expressed and enacted the cycle of love, hate and reparation; her need to love and belong, her need to be separate and destroy, and her need to undo her destructive impulses.

Carol's illness has other significant functions within the family. It allows Carol to express the feelings of fear or helplessness for others, who can then disown such feelings in themselves and act in a responding and caretaking capacity. In this way Carol may be considered as a kind of siphon or amplifier for the unacknowledged, unspoken but important and persistent feelings of others. Mrs F's covert emotional life has already been discussed, but what about Mr F? Perhaps Carol's illness might serve as a way for him to express both his tenderness and his frustration, which is so hard for him to share directly with his wife. Carol, as a constant focus of attention, creates a route by which Mr and Mrs F can both communicate and avoid one another; they talk a lot about Carol, but little about themselves. Carol thus becomes both a shared concern and a buffer between them. If they were deprived of Carol's sick-role, the difficulties between them would emerge more sharply and inescapably.

For Brian and Sue, too, Carol's illness has its functions. So long as mother's attachment needs are channelled into her care and concern for Carol, they are not discouraged from making other relationships outside the home and eventually growing apart from their mother. Should Carol become well, the mother's fear of separation would be transferred to them with greater intensity.

Table I summarises a psychodynamic analysis of Carol's illness.

Carol	<ul style="list-style-type: none"> (1) Keeps mother loving and safe in the only way she knows how (2) Expresses anger and also reparation for her guilt from her fantasized anger (3) Makes mother and father seem closer together
Mrs F	<ul style="list-style-type: none"> (1) Keeps Carol close and special for her where Mr F has disappointed her (2) Helps her avoid issues of abandonment and aloneness (3) Allows Carol to express her own (Mrs F's) (unexpressed) vulnerability, fear and impotence
Mr F	<ul style="list-style-type: none"> (1) Allows him to show care and concern where this is difficult in other situations (2) Produces a common problem through which he can relate to Mrs F
Brian and Sue	<ul style="list-style-type: none"> (1) Deflects mother's oversolicitousness, thereby enabling them to be more autonomous (2) Makes mother and father seem closer together
The marital system	<ul style="list-style-type: none"> (1) Makes for a common bond between Mr and Mrs F when this would otherwise be lacking (2) Deflects feelings of neglect, resentment and uncertainty about marriage which would otherwise have to be encountered
The family system	<p>Produces cohesion by:</p> <ul style="list-style-type: none"> (1) Facilitating bond between Mr and Mrs F (2) Projecting otherwise disturbing difficulties and feelings into one family member thus leaving the others feeling unthreatened and unencumbered

Table 1: Relational and psychological factors in the patient's illness

This summarised table contains hypotheses which are inferential rather than directly observable, and this is generally true of psychological and psychodynamic formulations. How do we know if they might be true? There are two main methods which can be used.

Empirical and deductive method – Our hypothesis will make sense of otherwise disconnected facts, and predict usefully what might happen in future.

Deepening of rapport – Our interpretations, if skilfully conveyed to the patient, will lead to an increased thoughtfulness and increased disclosure and trust on the part of the patient in a manner which may bring about greater integration of split-off impulses and feelings, leading to change in symptomatology or behaviour. This will be examined further in the next section.

This empirical-deductive method of assessing psychological factors in illness is usefully illustrated in Carol's case. After hospitalization her asthma became much less severe, but she became seriously school-phobic and was referred to a child-psychiatrist, where the problem was eventually tackled in a family-therapy context. Her school phobia dissolved over a period of months, probably hastened by father's decision to change his job to that of a shore-bound ship's pilot. Although Carol's asthma became quiescent, and her school phobia resolved, her parents continued to attend the hospital for marital therapy, as problems were now emerging between them which they recognised as being theirs, not Carol's. This would be a likely prediction of the above formulation, and reinforces the notion of Carol's illness being the function, in part, of other family processes.

Level of rapport and the nature of diagnosis

If, as suggested, Carol's illnesses reflected unresolved conflicts and tensions at an intrapsychic and interpersonal level, how is an attending doctor to make use of this notion? As we saw, Dr V had noticed Carol's introspective submissiveness, the mother's overprotectiveness and hypochondriasis, and the father's rather truculent but protective attitude. He made a cursory attempt to understand the situation better by, for example, asking Carol 'Are you worried about anything?', but this was met by mother's resistance in the form of denial. Perhaps the doctor's question was experienced by Carol and her mother as being too bald to yield candid exploration.

Psychological examination has intricacies similar to the physical examination and untimely questioning evokes a similar response to the sudden production of a doctor's cold hand on a frightened patient's abdomen. The doctor's shifting from a physical to a psychological frame of reference may have been too abrupt for the patient to adjust to and assimilate.

It is now well established that response and compliance to taking prescribed drugs are significantly influenced by the size, shape and colour of the tablet or capsule. This principle is likely to be even more important in what we offer the patient verbally. How we offer an interpretation is perhaps more important than its content.

Dr V could, perhaps, have gone some way to bridging the gulf between his observations (Carol's passivity, Mother's anxiety) and the presenting complaint (Carol's asthma, Mother's hypochondriasis) by phrasing his question differently. With Mrs F, for example, he could say: 'I've listened to your story, and by examining you I can tell you that there is no serious disease causing your headaches. From experience we know that in many people the pain is due to tension in the body. With all of us, if we have strong or mixed-up feelings which we can't put into words or get rid of, then these feelings get stuck in different parts of our body, to cause tightness or pain. Sometimes I've thought that you look as though you have a lot of worry which you can't express or let out, so I wonder if you think this could apply to you?'

This form of question is more likely to be considered by Mrs F than the more direct, 'Are you worried about anything?', as it demonstrates the doctor's serious recognition of Mrs F's pain, and also offers her an explanatory link between her dualistic,* and his monistic,* frame of reference. If Mrs F were to pursue his suggestion, there follows a change in the level of rapport. Referring back to figure 1 we can see that her presenting complaint (headaches) is at level (f) – organ symptomatology – while the doctor's suggestion is at level (g), (h) or (i), depending on whether she chooses to focus on, for example, her own feelings (g), her anxieties about Carol (h) or the difficulties in the F family as a whole (i). If the level of rapport changes to one of the other levels, the diagnostic formulation will also change, as shown in table 2.

Level of rapport = level of organising concept of illness (see fig.)	Type of diagnostic formulation
(f) Organ pathology and symptomatology	'Functional headache' 'Atypical migraine'
(g) Emotional/cognitive	'Anxiety neurosis'

	'Obsessional ruminations over loss etc'
(h) Interpersonal	Extended symbiotic attachment of mother and daughter
(i) Family system	Complex family tensions projected into somatic breakdown in two family members

Table 2: Level of rapport and type of diagnostic formulation

In the F family the level of rapport presented itself, and remained for some time, at level (f) so that Dr V was dealing with Carol's asthma and eczema, and Mrs F's headaches, in a physical and dualistic manner, by conventional drug prescription. Communication between patient and doctor was confined to the events and language of organ disturbance and, consequently, diagnosis was in physical syndromes.

When Carol was first referred to the child psychiatrist because of her school phobia, she was initially seen individually and their communication was focused on Carol's fear of her angry feelings and the fantasies which she had of what would happen to mother, were she to leave her at home by going to school. The diagnosis now became that of the neurotic anxieties of the little girl.

The decision to take the F family into therapy changed the level of rapport again. The communicated problems led to a diagnosis of Carol's anxieties within a matrix of unexpressed marital tensions, whereby the mother's fear of Carol's separating from her reflected a displacement of the anger and hurt she felt towards her husband in this respect, and, reciprocally, Mr F's fear of closeness and the demands he felt which more substantial commitment would lead to.

All these observations and inferences are part of 'the psychosomatic mosaic'; no one part expresses the whole on its own and each part, ultimately, only makes sense with reference to its place among the others. Equally important, no one part 'causes' the rest of the picture to be formed, although it is true that at times one part of the mosaic will become more prominent and demand separate and complete attention. Carol's severe asthma attack needed immediate physical attention (level (f)) and an

interpretation of her repressed anger (level (g)) at the time might be 'correct', but would certainly be untimely. Eventually, however, such an intervention made a substantial contribution to the holistic approach to her care.

The F family represent a fairly unusual example of illness in which the psychosomatic mosaic can be seen in a fairly whole form, albeit retrospectively, and after much professional time had been spent in broadening the rapport in a number of different contexts. More often the doctor is familiar only with one or a few pieces of the mosaic, perhaps because he is too busy and has neither the inclination nor the training to seek, or assemble, the other pieces. Usually such elaborate endeavour is not asked for, or needed, by the patient and would thus become an unnecessary professional burden or intrusion.

Sometimes, as illustrated by the case of Mr A in my article *A Psychosomatic Approach*, the doctor may wish to broaden the pattern of communication which the patient brings in somatic form, although the patient may steadfastly hold to his physical symptoms. Clinically we might label such a patient 'hypochondriacal' or suffering from a 'depressive illness with somatic manifestations'. In psychodynamic terms the patient is employing a somatic defence whereby conflicts or impulses which are intolerable to the conscious mind or the patient's *modus vivendi* are split off and expressed by the body, leaving the conscious 'self' clear and unthreatened.

At times such a defence represents an acceptable and efficient working compromise between the self which is known, and the self which is forbidden. In these instances a doctor's zealous attempts to complete the mosaic would be fraught with difficulty; premature removal of defences is likely to be followed by a decompensation of the underlying psychopathology. Like inflammatory tissue, such defences are primarily protective and only secondarily pathogenic. A woman whose feeling of a lump in the throat, for example, is a defence against her unconscious wish to scream at and assault the dying mother she cares for, might be managed best along wholly physical lines; unmasking the conflict might be more than she can bear.

On the other hand, Carol F perhaps represented the opposite pole; the somatic defence was progressively decompensating and dangerous, but the underlying material was accessible and, with skilled help, could be worked through advan-

tageously. The question of when and how to expand our rapport and diagnostic image of patients is probably as important as the more traditional and familiar medical practices. The skills which we need, to be sensitive to such nuances, are as intricate, and at times as important, as any the doctor has learned in his conventional training.

**For the special sense in which the words 'dualistic' and 'monistic' are used the reader is referred to the previous article 'A Psychosomatic Approach'.*

The Practitioner April 1982 Vol. 226 711

Version: 19 March 2015