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Psychosomatic potentiality and its relationship to ego development and self-representation

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Psychosomatic Potentiality and Its Relationship to Ego Development and Self-Representation

by

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"...Every human being is capable of creating a neurosis,
a psychosis, a pathological character pattern,
a sexual perversion, a work of art, a dream,
or a psychosomatic malady."

Joyce McDougall (1974)

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ABSTRACT

The present study explored psychosomatic phenomena by examining the relationship of self-reported somatic complaints to ego development and self-representation in a nonclinical adolescent population. The study was conducted with 246 adolescents, 98 males and 148 females, ages 14 through 18 years. The adolescents' scores on somatic items of the Youth Self Report (YSR)(Achenbach, 1982) were examined with categories of ego development (Washington University Sentence Completion Test (SCT) Loevinger & Wessler, 1970) and dimensions of self-representation (Pace Profile: Positions in Adolescence (PIA), Hart 1988).

The central hypotheses predicted relationships among self-reported somatic complaints, ego category, gender and self-representation. Results of analyses confirmed the hypotheses that Ego Development Category explains self-reported somatic complaints. A trend analysis affirmed a significant quadratic component for boys and for girls, demonstrating a curviliear relationship between ego category and somatic complaints. Somatic complaints were reported with greater frequency by the Preconformist and Postconformist subjects.

The results also supported the hypothesis that the self-representation positions would be related to the frequency of somatic complaints. The overall relationships were such that the positions more reflective of pathology correlated positively with somatic complaints and those which reflect health correlated negatively with somatic complaints. The results supported the

existence of gender differences in the frequency of reported somatic complaints. The findings suggest that females report more somatic complaints than do their male counterparts. Post hoc tests revealed that the items contributing most strongly to the differences were items associated with the menstrual cycle.

The interactive model which proposed that the relationship between somatic complaints and self-representation would vary at different levels of ego development within and between the sexes was not supported by statistical analyses. However, subsequent correlational analyses revealed significant relationships between self-reported somatic complaints and self-representation positions at the various ego categories. The findings were discussed in relation to contemporary psychoanalytic theory. Additionally, practical implications for the identification and referral of psychosomatic adolescents were addressed.

CHAPTER I

INTRODUCTION

Statement of the Problem

The relationship between mind and body has fascinated and mystified philosophers and scientists throughout history. In the twentieth century, there has been a growing attempt on the part of psychoanalysts to understand the delicate and permeable boundary which exists between the psyche and the soma.

Psychoanalysts beginning with Freud have pondered the etiology and meaning of psychosomatic illness. Most contemporary analysts attribute etiological significance to the modes of understanding and communication in the mother-infant dyad (Edgecumbe, 1984; Winnicott, 1960; Fain, 1963, cited in McDougall; McDougall, 1974, 1980). The earliest patterns of interaction in the mother-infant dyad serve to organize the infant's somatic and psychic experiences and to determine the infant's ability to manage, contain and express affective states. In somatization, the body expresses emotions whose origins have not been identified, and thus, conflicts and desires are felt as somatic experiences. While body language, or somatization, functions in infancy to alert the mother to the infant's basic needs, that is, her/his tensions, desires, hunger; in adolescence and adulthood, more complex experiences, reactions and needs cannot be adequately communicated (Edgcumbe, 1984).

While incidence and prevalence figures vary, there are strong indications that psychosomatic illness accounts for many

physician appointments and emergency room visits. This holds true for children and adolescents, as well as for adults. Starfield et. al (1980) reported that children and adolescents with psychosomatic illnesses accounted for between 5.7 and 10.8% of all pediatric patients.

Adolescents undergo dramatic physical, developmental and sexual maturation. The somatic complaints which often accompany these changes may reflect the normal stresses of this developmental stage, or may be indicative of either real or perceived threats to the adolescent's sense of self; or, significant feelings of loss, inadequacy, or despair. Their emotional distress often goes unnoticed by parents, school personnel and other professionals. The accurate assessment of, and appropriate referral for these adolescents is critical, particularly in light of the high incidence of maladaptive behaviors, depression, and suicide in the adolescent population.

The author hopes to provide an understanding of psychosomatic symptoms in a non-clinical population of adolescents by exploring the relationship between psychosomatic complaints, ego development and self-representation. Such knowledge will serve to inform parents, school personnel and physicians which might then prompt appropriate referrals and subsequently, adequate treatment. In addition, the exploration will help guide the psychoanalytic treatment of psychosomatic adolescents.

Review of the Literature

History of Psychosomatic Thought

The popularity of psychosomatic concepts has been inextricably linked with the cultural climate of the times, flourishing in times of intellectual curiosity and scientific growth, and fading in more conservative and reactionary times. In ancient times, physical illnesses were thought to be punishments by the gods or by malignant spirits. Ceremonies of healing occurred in temples where music, dance and prayer were utilized to drive evil spirits away.

By the fifth century B.C., more rational approaches grew in the intellectual climate of ancient Greece. Hippocrates emphasized the importance of the relationship between the patient and the physician, and the role of the environment and of adaptive factors in health and in illness. Health was regarded as natural homeostatic harmony, and, in contrast, disease was viewed as resulting from an imbalance in the interaction among: the four essential elements that compose the earth; the four humors that control health and illness; the basic character types corresponding to the humors; and cosmology (Schwab, 1985).

When the ancient Greek and Roman civilizations declined, so did the more rational, scientific understanding of the mind-body relationship. All illnesses, particularly mental illnesses, were considered religious concerns. Demonology was viewed as causal in the afflictions of the body and the mind.

This explanatory mode remained prominent throughout the Middle Ages.

The Renaissance once again brought a revival of learning, a weakening of the influence of the Church, and the development of science. Bacon advocated a new experimental method to investigate the relationships of the mind and body, and between the individual and society. He wrote of "...the sympathies and concordances between the mind and the body, which being mixed, cannot be properly assigned the sciences of either" (cited in Schwab, 1985, p. 584.).

In the sixteenth and seventeenth centuries, the introduction of quantitative measures in the sciences led to new discoveries and observations. In the Hippocratic tradition, physicians noted the influence of events and emotions on physical health. At the same time, Descartes further developed the concept of Dualism, which appealed to many theologians, philosophers and scientists. This separation of the mind and the body did not threaten the established social order and the authority of the Church. Until the mid-eighteenth century, the concept of dualism thwarted the spread of any theories espousing mind-body unity (Schwab, 1985).

The decline of the authority of the church and feudalism, and the triumph of rationalism in the latter part of the eighteenth century, led to an intellectual climate in which the influence of emotions on physical illness could be legitimate areas of study. In the early nineteenth century, Reil, a

physician and researcher, first used the word psychiatry. He viewed the human experience as a unity of the mind-body experience. And, Heinroth, the first professor of psychology at the University of Leipzig, was the first to use the word psychosomatic. His school of followers, the Psychiker, maintained that an understanding of the mind in health and illness was essential (Schwab, 1985). However, these views were soon rejected as abstract and scientifically invalid and in the latter part of the nineteenth century, psychosomatic concepts were, once again unpopular.

In Paris, Charcot was working with hypnosis to eliminate symptoms without organic basis, demonstrating the power of the mind over the body. Sigmund Freud, then a young neurologist from Vienna, travelled to Paris to learn the technique. He returned to Vienna to apply hypnosis to his patients suffering with conversion symptoms. He soon began a collaboration with Breuer, a more established physician, who was also experimenting with hypnotism. A groundbreaking book, Studies in Hysteria, resulted from this period of collaboration.

These studies laid the foundation of psychoanalytic theory, the concept that all communications; associations, parathesias, conversion symptoms; were expressions of desires and wishes which were unacceptable to one's personal and societal values. Thus, these feelings were repressed, becoming part of the unconscious. They posited that, while outside of one's awareness these feelings continued to impact on the functioning of the individual

(Freud & Breuer, 1893-1895).

In the twentieth century, the mind-body problem has come under the purview of psychoanalysts who have attempted to understand the complexity and richness of this relationship.

Psychoanalytic Theories on Psychosomatics

"...The unconscious exerts on the somatic processes an influence of far greater plastic power than the conscious act ever can."

Freud (1917)

Two major psychoanalytic hypotheses have been formulated to explain psychosomatic symptom formation. Both emphasized the critical importance of the separation process which occurs in the context of the mother-child relationship. Core representations of self and other arise through the separation process. These internal representations provide the basis of an individuals' sense of self-definition and identity (Winnicott, 1960; Klein, 1948). One hypothesis maintained that psychosomatic individuals exhibit global deficits in affect regulation, internalization and symbolization. The other school of thought proposed that psychosomatic illness occurs as a result of weaknesses in representational capacity and regression to earlier modes of coping.

The Deficit Theory of Psychosomatic Illness: The Paris School

According to proponents of this school of thought, including Winnicott (1966) and McDougall (1974, 1982, 1989), ego weaknesses arise as a consequence of an early impingement of the maternal

shield, that which Winnicott termed 'not good enough mothering'. Individuals who have experienced such impingements demonstrate deficits in the mental representation of the maternal image. The weakness in representational capacity leads to disturbances in affective, symbolic and self-care functions, as well as disturbances in the mental representation of the body. These difficulties are ultimately expressed in psychosomatic symptom formation. The deficit described suggests a relationship between psychosomatic phenomena and lower levels of ego development, ego development being contingent upon self-other differentiation and self-object representations.

Adolescent and adult individuals prone to serious somatization have been described in the literature as demonstrating pseudo-normality (McDougall, 1974) and normotics (Bollas, 1986) which both refer to a mode of operating in the external world with a robot-like adjustment (McDougall, p. 444). In addition, psychosomatic individuals are thought to display: more primitive defenses, unavailability of affect, a lack of imaginative capacity, and difficulties with verbal communication (McDougall, 1974; Edgecumbe, 1984; Neri, 1985; Vassend, 1987; Gustafson & Kallman, 1990).

Gustafson and Kallman (1990) compared adult patients who carried the diagnosis of primary somatic body pain with those who carried the diagnosis of secondary psychosomatic body pain. The diagnoses were made at a pain clinic after extensive clinical somatic evaluations and psychological depth interviews. They

found that the psychosomatic patients utilized more primitive defenses than did the somatic patients. Such results support the model which predicts a linear relationship between ego development and psychosomatic phenomena.

The Regression Theory of Psychosomatic Illness

The other major psychoanalytic school of thought, represented by Schur, Sperling and Krystal, postulated that, in most respects, psychosomatic individuals have adaptive ego functions and, the psychosomatic symptoms result as a consequence of a regression to earlier modes where infantile responses to stress and anxiety are reactivated.

Krystal (1978) discussed regression as a possible response to infantile or adult trauma. He proposed the existence of varying degrees of severity of illness and, along that continuum, regression from a position where affects were verbalized, desomatized and differentiated to a position of undifferentiation and resomatization. Thus, the regression results in the development of psychosomatic phenomena. Krystal maintained that the self-representations of psychosomatic individuals prohibit self-care and true ownership of their bodies. The failure to assume the self-care function is inhibited in order to protect the connection to the mother (Krystal, 1978). Mothering activities are reserved for the mothering one who has not been adequately internalized.

Sperling (1968) also attributed psychosomatic phenomena to regressions to earlier coping patterns. She maintained that

psychosomatic individuals have internalized an image, however, the image is of a pathogenic symbiotic relationship. She noted that the psychosomatic relationship, while originating earlier in life, becomes evident in the anal phases of development as the maturational processes allow for a greater degree of separation. Separation at the anal stage is fraught with the toddler's conflicting set of wishes for separation and blissful merger. A secure attachment at this stage enables the process. However, Sperling believed that in some individuals, the internalized image of the mother demands denial of aspects of the child's aggression, sexuality, self-assertion and striving for independence. Thus, any assertion or impulse toward assertion in these individuals results in the fear of object loss. The child feels accepted by the mother when he/she is symptomatic and rejected when he/she is healthy (Sperling, 1968).

The psychosomatic response reflects a compromise formation, a pathological solution to the unresolved separation conflict. The psychosomatic individual achieves immediate discharge of impulses, wishes and fantasies, via a relationship with an internalized object. The impulses are acted out internally in the various symptoms. Sperling elaborated similarities between the psychosomatic patient and the acting out patient. She attributed these similarities to the patient's common intolerance of tension and the urge for immediate discharge. Additionally, she described both types of patients as demonstrating a need for omnipotent control of their objects (Sperling, 1963). Sperling