

Psychosomatic Aspects of Illness

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All illnesses have psychic and somatic components, just as each human is an integral product of mind and body

The time is now long past when our patients and their symptoms were divided into 'organic' and 'functional'. Patients' distress always has varying proportions of the two. The division is usually an invitation by a somatic clinician to convey distress in somatic terms, because that is what the clinician understands. The 'functional' part may be subjected to endless tests 'in case something treatable (organic) has been missed', for 'functional' often means a wastebasket of conceptual and therapeutic nihilism.

Most studies show that 50% or more of patients attending the primary care physician have basically 'functional' disorders. This is a frightening proportion of medical distress which is often not grappled with properly.

It is recognised that in medical education there is precious little to prepare the doctor for the onslaught of common everyday problems. It is also recognised that it is impossible to take full psychiatric histories from all patients. In any case, often they too are biased to a particular view of the patient, i.e. the psychiatric textbook syndromes. Most patients presenting to the primary care physician do not have a psychiatric illness *per se*.

This article is a pilot attempt to provide a meaningful holistic approach to the patient. From table I it will be noted that there are 8 categories which can be considered from the points of view of clinical facts, and their implications for

history-taking and conceptualisation, and subsequent therapeutic management. It will also be noted that the first 2 points relate to background, the next 5 generally to current illness with increasingly 'functional' loading, and the last point to secondary effects of illness.

The Patient's Personality: Who is this Person?

Clinical Aspects

There is such a wide range of reactions to stress and subjective distress by patients to the same pathological entity, that obviously personality plays a large part in an individual's illness. It is as well to remember Osler's aphorism to the effect that it is more important to know what sort of person has a disease than what sort of disease a person has.

Case History: A night wireless operator on a ship insisted on premature discharge following his myocardial infarction. He was of the 'difficult patient' type. It appeared

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TABLE I. Steps in assessing patients

Clinical aspects	History	Treatment
1. Patient's personality is important	Assess personality. Who is this patient?	Take personality into account in treatment
2. Stressful events precede illness	What preceded this illness?	Treat the stress
3. Many illnesses are typical, textbook-like physical illnesses	Does the illness have a somatic 'signature'? Elicit medical history	Treat somatic illness stress and preceding stress
4. Autonomic nervous system activation produces diffuse symptoms	Does the symptom have a physiological 'signature'? Elicit physiological history	Treat physiological symptoms and preceding stress
5. Many symptoms are accentuated because of psychosocial factors	Does the illness have a hysteria-like 'signature'? Elicit psychosocial history	Treat the symptom and psychosocial stress
6. Somatic symptoms may be part of psychiatric syndromes	Does the illness have a psychiatric 'signature'? Elicit psychiatric history	Treat psychiatric illness and preceding stress
7. Identification with another may produce symptoms	Does the illness have an idiosyncratic 'signature'? Elicit grief, identifications with others	Treat grief, guilt, anger
8. Each illness has secondary effects	What are the secondary somatic, psychic and social effects of illness?	Symptomatic — depends on the reactions

that he was a social isolate, who, whenever the ship was in port, had to contain his anxiety by getting drunk. Thus, being in a ward full of people without alcohol was more stressful to him than being on board ship working. Once this was realised, he was able to be discharged to his ship with the full cognisance of the ship's surgeon and the ship's authorities.

Historical Approach

The basic question is 'Who has the illness?' This is a very complex question on the one hand, but on the other, one which the family physician is singularly well placed to answer. One approach is to question what the patient's characteristic defences are, whether they are now pathologically extended or whether they have indeed broken down. For instance, whether a driving type A personality is working even harder, or has given up working in despair; or whether a generally anxious person is even more anxious, or in a panic.

Therapeutic Approach

This will have to be tailored to the patient's personality, otherwise the patient will join the ranks of non-compliers who constitute the majority of most practices. For example, it might be useless to ask a very passive person to be in charge of his or her treatment. Better results might ensue from allowing the dominant spouse to stay in charge. Similarly, a driving independent person won't take kindly to the spouse being in control, nor indeed the physician. 'Take it easy!' type of advice may well be rejected. More cooperation may be gained by giving the patient the feeling that he is achieving measured objectives in his rehabilitation.

Each patient requires at all times the correct balance between support and encouragement to self-sufficiency. If these are not given at the rate the patient can digest them, the patient becomes 'difficult' or over-compliant and dependent [1]. In any case, the therapeutic alliance is disrupted. This is the cost of applying treatment to the patient without taking into account the 'human' factor.

Preceding Stresses: What Happened to the Patient?

Clinical Aspects

Retrospective and prospective epidemiological studies have now amply confirmed that illness does not occur randomly [2, 3]. Rather, highly stressed individuals have more illness, and illnesses in individuals tend to cluster around crisis periods in their lives. What is surprising, is that all illness tends to be preceded by stress, i.e. psychiatric illness, somatic illness, surgical illness, and even illness resulting from accidents. Furthermore, the number and severity of these illnesses is proportional to the intensity of the stresses. It is also of interest to note that the greater the incidence and severity of somatic disease, the greater is the incidence and severity of concurrent psychological disease, and vice versa.

Holmes and Rahe [4] have rated severity of stress. The top 3 stresses relate to loss of spouse — the death of a spouse having a mean value of 100, divorce 73 and separation 65 units. Death of a close family member rates 63 units, as does a jail term. Other stresses include other family and work crises. Thus, grief over loss is the major stress, with other threats to security following.

Not only the stress is important but the perception of it in the individual is also important. The feeling of despair and of having given up in the face of the stress, has been noted to be an important precedent in illness [5].

Case History: A 44-year-old patient was diagnosed as having stage 1 carcinoma of the cervix. A year prior to this her disseminated lupus erythematosus flared up on the background of severe marital problems. She was treated with cortisone and developed morbid jealousy leading to psychiatric hospitalisation. Her marriage deteriorated after her discharge. She then turned 44 years of age, a further stress to her because she had lost a very close sister at that age from cancer. It was in this atmosphere of despair in a failing marriage and identification with a dead sister that irregular bleeding developed and led to the diagnosis of her own carcinoma.

Historical Approach

The first question asked was 'Who is the patient?' The question now is 'What has happened to this person, and why should he have this particular illness at this particular time?'

Specific questions should be asked in relation to recent griefs, losses, and marital tensions. For children, the tensions are usually related to the parents. Irreconcilable conflicts should be enquired about, be they in the family, at work, or any other meaningful area of the patient's life. Feelings of hopelessness, 'having had it' and frustration are elicited, and their source searched for.

All this requires a new listening capacity, and new questions: 'What's been going on?' rather than 'Where is the pain?' Irrelevant ramblings such as 'It was when my hus-

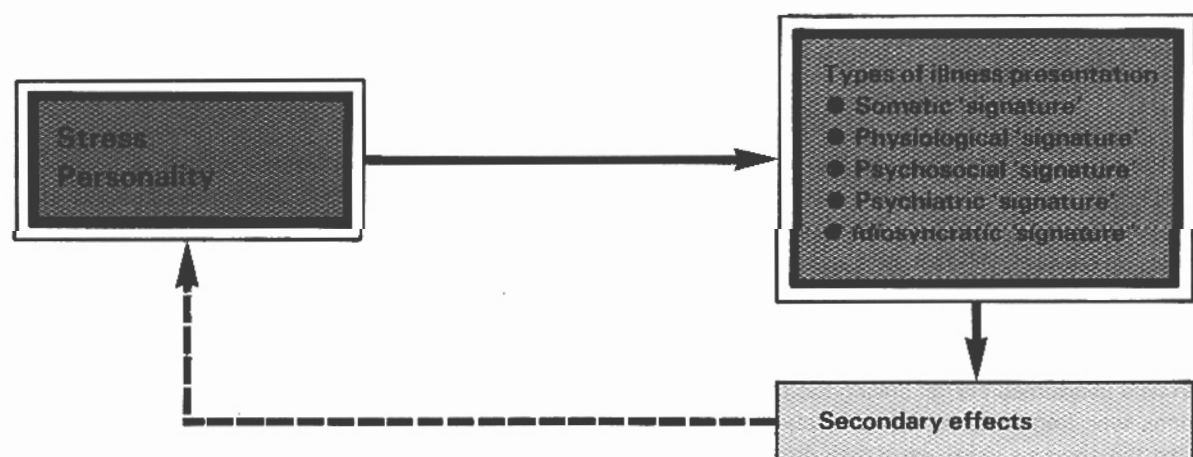


FIG. 1. Factors to be assessed in illness.

band came home from the pub and said... may now assume for the doctor, the importance that they obviously have for the patient.

Therapeutic Approach

Return of the patient to unaltered stresses will mean continuation of illness, maybe with everchanging symptomatology. Some social manipulation may be open to the doctor: advice, reassurance, a sympathetic ear, or appropriate referral, e.g. to marriage guidance.

Even the simple mechanism of making a stress conscious can help patients to get the stress into perspective. Presentation of alternatives may change their state of hopelessness and helplessness and allow reconstitution of their defences.

The stress will not always be amenable to resolution. However, allowing the patient some resumption of control in the face of it may provide a foundation for future mental and physical wellbeing.

Does the Illness have a 'Somatic Signature'?

The term 'signature' is borrowed from Engel's review [6] on differentiation of psychogenic and somatic pain. Yet most illnesses also have their special 'signatures', and somatic illnesses have the 'signatures' (signs and symptoms) which are described so well in medical textbooks, e.g. for acute appendicitis, pneumonia etc. It is this 'signature' that most medical approaches are intent to find, and of course often do so.

Historical Approach

After finding out who the patient is and what has befallen him in recent times, the next step is the classical medical history.

Yet even here the importance of the prior 2 questions should not be overlooked. It should be remembered that *all* illness tends to have antecedent psychological stress.

Note, for instance, the person injured in an accident. Why did the accident happen just then? For example, the woman who overturned her car driving too fast for the road conditions was immersed in thoughts about her brother who died the previous week; or, a man drove into another car on his way to his therapist 2 days after his wife left him.

The classical psychosomatic illnesses often have obvious emotional precursors.

Case History: A woman aged 55 years had developed asthmatic attacks at times of enforced passivity during the war, e.g. she was in status asthmaticus during a prolonged bombing attack. Now she has attacks when she feels herself to be the passive victim of her husband's and brother's attacks.

Case History: A hard working 45-year-old, morally rigid, type A man felt hopeless in the face of his children's rebelliousness. When finally criticised at work, he developed angina, which recurred with each criticism. When a family death was added to his troubles, he had a myocardial infarction 10 days later.

Therapeutic Approach

This is 2-pronged. The classical somatic treatment for the somatic aspects of the illness is essential here, but treatment of stresses and reactions to them may be just as important (see above).

Another point of importance is that if an illness does not have a somatic 'signature', there should be no desperate attempt to find one for it through numerous tests, ill-advised operations etc. Its 'signature' may be found in the following sections, which are often collectively lumped together as 'functional overlay'.

Has the Illness a Physiological 'Signature'? Can the Symptom be Explained through Autonomic Nervous System and Arousal/Dampening Effects?

Clinical Aspects

Maybe the majority of somatically determined complaints do not fall into the well defined hospital/textbook-like somatic syndromes, but rather into diffuse symptoms such as tiredness, indigestion, decreased appetite, diarrhoea or constipation, dizziness, shakes, palpitations, headaches and other apparently atypical aches and pains.

Many of these symptoms are explicable on the basis of physiological hyperarousal and dampening, and sympathetic and parasympathetic system discharge.

Mental analogues of these symptoms are vague anxieties and depressions, a feeling of 'having had it', confusion, lack of concentration etc.

Historical Approach

One should be aware of the wide distribution of the physiological manifestations of distress. The short term and physiological nature of the presenting symptom can be corroborated by eliciting other concurrent symptoms of anxiety/arousal or dampening. For example, the presenting symptom of dizziness or headache may be accompanied by palpitations, a need to urinate frequently, apprehension etc. This is some circumstantial evidence for the nature of the initial symptom.

An interesting way to reproduce many of these symptoms in the clinical situation is by asking the patient to overbreathe for 2 minutes. Not only the symptoms of overbreathing are reproduced, but also many of the other physiologically determined symptoms. It may be that overbreathing in the clinical situation produces sufficient anxiety in many to reproduce their symptoms.

The diagnosis is often clinched by eliciting the pattern of onset of the symptom. This is related to onset of stress, e.g. half an hour before husband comes home, whenever left alone, etc.

Therapeutic Approach

Explanation of the nature of the symptoms can be very reassuring, so can their reproduction through overbreathing. Especially reassuring may be the demonstration that many of the symptoms can be made to disappear by breathing into a paper bag. Drugs may be used to alleviate the anxiety, and subsequent muscular tension. Relaxation therapy, yoga etc. have all been tried with varied success. But nothing can be as effective as resolving the stress which brings on the symptoms.

Has the Illness a Hysteria-like 'Signature'? Is there Primary Gain in the Illness?

Clinical Aspects

It is assumed by clinicians that an illness creates distress. Yet at times an illness may be an unconscious vehicle for diminishing anxiety, much the same way as a soldier's wound may be a highly prized acquisition, or the paralysed arm of the hysteric creates little anguish to the patient.

Case History: A 44-year-old man who was a previously good worker (as these patients often are), lifted a weight at work and strained his back. His symptoms were far in ex-

cess of somatic pathology. Prior to the accident the patient was anxious as he felt that he was becoming estranged from his wife. His 'illness' gave him an honourable way to stay close to his wife, and his anxiety diminished.

Any symptom, accident or illness may serve to produce a net decrease in anxiety or distress. Thus an accident or illness may be but one part of a psychosocial process. This process has been variously called 'accident process' for accidents [7] and 'illness process' for illnesses in general [8]. In this case, the illness is actually unconsciously valued. Doctors are really asked to confirm the illness, not take it away.

These patients often present dilemmas and frustrations with their excessive disabilities, and clinicians' inability to make them better. Because these patients often have some degree of somatically based disability, they are given the full round of investigations and attempts at treatment for their excessive disability, the underlying process being missed.

It is for such patients that fashionable diagnoses are invented to incorporate their symptoms into a somatic model, e.g. 'effort syndrome', many 'hiatus hernias', 'low back syndromes', 'post-concussion syndromes' etc.

These diagnoses give both doctors and patients a modicum of respectability in the face of an illness with a known (though puzzlingly) bad prognosis.

Historical Approach

Does the clinician feel he cannot 'win' with the patient? Is there too much disability for the amount of pathology? In spite of the professed severity of the symptoms, does the patient seem relatively unconcerned, and seem to do little to help himself?

These are the clues. Uncovering the underlying conflict may be difficult here, because the patient will not cooperate. The conflict is now unconscious, and the thrust is towards resolving it through illness.

The clinician's therapeutic interference may be resented, or met with symptom substitution, or the patient may change his doctor.

Therapeutic Approach

This must nevertheless revolve around finding and resolving the underlying conflict. The clinician must impart to the patient the trust that *he* does not consider the underlying conflict shameful, nor that it is hopeless. Better alternatives than giving up function must be sought.

Does the Illness have a Psychiatric 'Signature'?

Many somatic symptoms are part and parcel of classical psychiatric syndromes described in psychiatric textbooks. These include endogenous depression with symptoms of anorexia, constipation, tiredness, sleep disturbance etc.; hypochondriasis as part of anxiety neurosis; the bizarre symptoms of schizophrenia including somatic delusions; and it should be remembered that hysteria can mimic any somatic disorder. Personality disorders add their own particular flavour to the symptomatology.

Historical Approach

The clinician should be aware of the signs and symptoms of the major psychiatric syndromes. Key questions relating to those syndromes should be administered in the same way that key questions are asked relating to the various systems in the somatic history.

Therapeutic Approach

Once again as for somatic 'signature' illnesses, the treatment is 2-pronged. If the illness is susceptible to drug treatment, very good results can be obtained, e.g. for endogenous depression and schizophrenia. But the other prong must still relate to the question as to why this person broke down when he did, and under what stress; the stress then needs resolution.

The caution that was sounded in the somatic 'signature' discussion against trying to mould illnesses into Procrustean beds of one's favourite perspective, must be sounded here too. It is psychiatrists who err most. If the illness does not fit a classical syndrome, other 'signatures' should be explored. For example, a somatic illness which underlies the atypical psychiatric syndrome may be missed, e.g. a brain tumour underlying an atypical depression.

Does the Illness have an Idiosyncratic 'Signature'?

Clinical Aspects

Patients often present with surprising naivete and without realising consciously, symptoms which they believe another person close to them suffered. The idiosyncrasy stems from the patient's own perception of a somatic illness in another, and the significance the patient attributes

to the symptom, i.e. the significance (often grave) it held for the other person.

The psychological mechanisms producing this mental replication of another's illness are identification and guilt. Identification is the attempt to be at one with the person one loves. The guilt towards that person stems from the aggressive parts of the feelings towards him. Being punished with the same affliction as that person suffered, satisfies both the desire for oneness and punishment.

Identification also often determines time of onset of the symptom — this may be soon after the other's death, or anniversary of it, or something symbolising it, e.g. the patient now being the age the other was at the time of death.

Case History: A 45-year-old man developed atypical chest pain which he believed to be a heart attack that would kill him. His father died of a myocardial infarction at 45 years of age, and the patient believed his current symptoms were like his father's before he died. The patient had often felt passive rage towards his father. Subsequent to the onset of the chest pain, it recurred thereafter in situations which for the patient symbolised the prior helpless rage towards his father.

Historical Approach

It is always essential to ask the patient for his own assessment of his symptoms, their significance for him and whether he ever knew anyone suffering the same sort of symptoms.

It is essential to enquire in the family history for the ages and causes of deaths not only of parents and sibs, but also of spouse, friends and other significant persons, and to enquire what particular symptoms these people had prior to their deaths, and when exactly these occurred.

Therapeutic Approach

Explanation of the identification and guilt processes may give some reassurance that 'it is all in the mind' and that the patient will not really die. However, the weight of therapy must lie in resolving the unconscious conflicts which cause the symptoms. The treatment is primarily one of resolution of grief and assimilation of all the feelings one has for the lost person. Because these feelings are able to be felt most acutely in the initial stages of grief, it is essential not to suppress these feelings then with drugs or 'stiff upper lip' attitudes. Prevention of these idiosyncratic (and one wonders how many somatic) syndromes can be helped by sup-

porting the grief process at the initial stage. Once the idiosyncratic syndrome is established, the grief has to be experienced belatedly along with the feelings of sadness due to loss, and rage against the lost person, leading to the acceptance of the loss. This requires psychotherapy.

Reactions to the Stress of Illness

Clinical Aspects

Illness itself is a stress which can give rise to further somatic illness, psychological reactions, psychophysiological symptoms and psychosocial dislocations. Detailed examination of these would require much more space, but some broad categories will be mentioned.

An illness may have its own specific complications, or diminish resistance to further illness.

Each illness will have some psychological and psychophysiological repercussion. Regression, anxieties relating to the illness and sadness due to loss of function are ubiquitous. Rage, guilt and despair may develop. The stages described by Kübler-Ross [9] for the dying process (denial, anger, bargaining, depression and acceptance) are applicable in some degree to all illnesses.

One illness which is often missed is the post-traumatic neurosis — an illness involving a great deal of the psychological reactions mentioned. These reactions are focused on a trauma of great magnitude — in fact, or as perceived by the patient. The characteristic anxieties, phobias, nightmares, and loss of self-esteem and security in the world, relate to the severe trauma both in time and content.

Each illness has secondary features, and the environment becomes enmeshed into them. It is here that we have the secondary gains of illnesses rearing their head with their psychosocial advantages. Money is only one such factor. Doctors and solicitors become embroiled in these secondary gains and sometimes have a hand in setting an illness on a non-therapeutic course.

Historical Approach

The clinician should always ask how a person is reacting to his illness physically, psychologically, and socially. The degree of mental 'fracture', regression, anxiety, anger and despair should be elicited, and thought of particularly when the patient's reactions seem irrational or difficult. Secondary gain factors should also be elicited. The question 'What

else, and who else (including the clinician) is in this illness?' should be asked.

Therapeutic Approach

When the reactions of anger, anxiety etc. are understood, treatment is often quite apparent [10]. For example, doctor availability, explanation to relieve excess anxiety and despair, reversing regression by giving patients responsibility, understanding their rage and guilt, prevention of secondary gains and making them conscious once they occur, all have a therapeutic value.

In summary, I believe that the above points can be easily integrated into the physician's conceptualisation of illness and approach to history-taking. The jarring dichotomy between a somatic history and subsequent psychiatric history (if taken at all) can be avoided. The time required to assimilate the points into a history is not great, yet it can elicit the vital initial clues for the bulk of functional components of illness.

However, it must be remembered that the above is only an initial screening process — just like the classical medical history when first applied to the patient. There will be complications, overlaps between categories and more question marks. But it would be surprising if this were not so. □

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