Psychosomatic symptoms: a contemporary psychotherapeutic exploration

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Abstract

According to the American Psychiatric Association (APA) "somatization disorder is characterised by at least four unexplained pain symptoms, two unexplained non-pain gastrointestinal symptoms, one unexplained sexual or menstrual symptom, and one pseudo-neurological symptom" (as cited in Egan & Kenny, 2011, p. 93). People that suffer from these symptoms are immersed in a continued use of primary care services. This can be a very overwhelming process when there is pain or sickness but no apparent medical solution.

The literature review explored how contemporary psychotherapy treats psychosomatic pain and illness. This exploration was approached by presenting different psychotherapeutic theories from Freud and Lacan to Object Relations Theory. These theories give an understanding of where these symptoms come from and which are the best psychological treatments.

The aim of this research was to explore how psychotherapists from different modalities comprising Cognitive Behavioural Therapy, Psychodynamic, Body Center Therapy and Integrative Therapy, work with psychosomatic symptoms. To achieve this, five accredited psychotherapists were interviewed following a semi-structured interview through which the use of open questions allowed the exploration of their underlying themes. A qualitative approach was chosen in order to gain a deep understanding of the experience of these psychotherapists working with psychosomatic clients.

The findings were compared with the literature review for validation of the themes. Some recommendations for further research have been added in order to continue this research which is very broad and complex.

Chapter 1 Introduction

1.1 Outline

Pain is defined by the International Association for the Study of Pain (IASP) as *"a disagreeable sensorial and emotional experience associated with a real or potential injury of the tissue or described in terms evoking such an injury" (Nasio, 2004, p49).*

With this definition, Nasio (2004) underlines that the IASP recognizes that pain is not only felt through an exclusively physical instance , i.e. like an actual wound, but also without any organic cause, such is the example of the psychosomatic symptoms manifested in fibromyalgia.

This research will explore the causes of psychosomatic disorders that do not have a biological cause. These disorders were named by Freud as psychoneurosis and actual neurosis. Both disorders have a sexual origin but a different aetiology. In the case of psychoneurosis, symptoms have a meaning and can be interpreted. The literature review focuses mainly on actual neurosis whose symptoms are of a somatic nature, that is without a symbolic meaning. Since these symptoms have a lack of meaning, Freud did not work with cases of actual neurosis because he considered patients suffering from it "*to be unresponsive to his psychoanalytic treatment*" (Verhaeghe, 2005, p1323). This is the reason why Freud focused more on psychoneurosis in his investigations.

Contemporary studies have continued with research about psychosomatic symptoms disorders which were classified by *DSM* -5 as *somatization and somatoform disorder (*Verhaeghe, Vanheule and De Rick, 2007, p1321*).* Both disorders don't have pathological causes.

According to Laplanche and Pontalis "*psychosomatic disorders are the modern day version of the actual neuroses*" (as cited in Chapman 1999, p2).

The research carried through in this respect by the School of Object Relations linked the early experience of the infant with the development of psychosomatic symptoms. Hence, the Object relations approach to therapy focuses on the early relationship between the infant and the caretaker which in most of the cases is the mother. The mother helps the baby program responses that the baby will use in order to cope with stress. To do this, the mother is attuned to the baby in what Schore (2001, p21), calls *affect regulation*.

Through affect regulation the infant learns how to control the Central Nervous System by forming a pattern in which it can explore the world and at the same time get comfort from the mother when it encounters new stressors. According to Schore (2001), the energy that is used by the Central Nervous System is not just to regulate the stress in the organism but also the emotional states (Schore, 2001, p14).When the mother fails in affect regulation, the infant faces a significant amount of stress so that it cannot cope with on its own. As a result of this failure in regulating affect, the damage caused goes beyond psychological distress insofar as the physical shake that happens in stress response.

Winnicott also focused his theory on the relationship between the mother or caregiver and the child. The infant's experiences of the world are lived through its relationship with the mother. The mother protects the infant by holding, handling and object presenting. Holding not just in a physical sense but also emotionally.

When the mother fails in these three duties the infant experiences primitive agonies which, according to Winnicott called annihilation or the feeling of "*going to pieces, falling forever, having no relation to the body, having no orientation in the world and complete isolation with no means of communication* (as cited in Gomez, 1997)

Gerhardt (2015) asserts that infants with insecure attachment are more predisposed to have "*illnesses with a psychosomatic component*" and also suggests that "*the immune system was linked to emotions*" (Gerhardt, 2015, p115). She also explains that due to the lack of emotional self-regulation, as a consequence of insecure attachment, the individual is not able to find words to express his feelings of distress, and therefore, the individual is prompt to somatize could somatize these emotions through the body. According to Verhaeghe et al (2007, p1335) the goal of attachment is the *"creation of a symbolic representational system*". People with no symbolic capacity have a lack of psychic elaboration , also called alexithymia which literally means "*no words for feelings*" (Verhaeghe et al, 2007, p1322).

Experiences in infanthood seem to be crucial in order to develop a healthy mind and body. But whenever this is not the case, psychotherapy could be a viable option to initiate the healing process. Wallin (2007) explains that love relationships or the relationships with a therapist can heal emotional injuries. This can be done by "*generating a relationship of secure attachment within which the patient's mentalizing and affect regulating capacities can develop*". (Wallin, 2007, p57)

1.2 Aims And Object

The aim of this study is to explore the causes for psychosomatic symptoms by investigating theories such as Actual Neurosis, hysteria as well as contemporary theories like object relations theory. This research will focus on psychosomatic symptoms with an emphasis on those which Freud called Actual Neurosis. The lack of symbolic function in these clients make them not suitable for therapies that work with interpretations or focus on helping the client to put emotions into words.

Following these the outcomes and findings of the research there will be an exploration of what type of techniques are currently being used by psychotherapists in the treatment of somatic pain. Furthermore the importance of the relationship between therapist and the client will be assessed.

The object of this research is to investigate what kind of psychotherapy works for the treatment of clients with psychosomatic symptoms.

Chapter 2 Literature Review

2.1 Introduction

There are many theories that try to explain how an individual develops psychosomatic pain or illness; the majority of them concluding that there is there is a strong linkage to an emotional component. This thesis explores the causes of psychosomatic pain according to these theories. For example, object relation theory links psychosomatic pain with the early development of the infant in its attachment relationship relation with the mother. Each theory suggests an exploration of the best treatment for such psychosomatic patients. The theories that will be explored are Lacan's Mirror stage, Actual Neurosis and Hysterical neurosis by Freud and the theory of Object Relations from the perspective of Melanie Klein and Winnicott among others.

2.2 Lacan's Mirror stage and the failure of symbolic representation

Lacan asserts the importance of the infantile experience in when establishing a relationship between the inner and outer world, and the significance of the relationship of the subject and its reality. This must be achieved in what Lacan called calls " *the mirror stage*" (Verhaeghe, 2001, p2). In this stage the infant gains its first sense of identity. According to Lacan (1977, p2) the child recognises his own image in the mirror. For this to happen the child has to master this image by repeating gestures and movements which he contrasts with the reflected environment until he realizes that the child in the mirror is himself. The mother has an important role in this process because she reinforces it by saying: that is you in the mirror.

Therefore, in this process of mirroring the mother uses language to name the baby's body, facilitating the baby's becoming aware of his own body. Lacan explains in his theory of the three registers, that the infant possess three bodies, or states of being; the symbolic, the imaginary and the real (somatic) as organism. The Symbolic refers to the meaning that the mother gives to the infant's body through the use of (her) language, the imaginary represents the infant's fantasy of his body, and the real is the somatic experience of the body; such experience being outside the realm of language. These three elements form the sense of identity of the infant.

Lacan also explains that a failure in the symbolic to represent a part of the real causes the "traumatic real" which is "*a part of the drive that cannot be represented"* (Verhaeghe, 2001, p6). The real has an impact on the unconscious: "*For what the unconscious does, is to show us the gap through which neurosis associates with a real - a real that may well not be determined*." (Verhaeghe, 2001, p6).

2.3 Neurosis and somatic symptomatology

Freud (1983-1899) concluded, through studying patients with phobias and obsessions, that there were neuroses with different etiologies: Psychoneurosis and Actual neurosis, both having a sexual origin yet with different etiologies; the former presenting a sexual aetiology of an infantile nature, whilst the sexual aetiology of actual neurosis relates to a genesis of an actual sexual life.

In psychoneurosis, neurotic suffering comes from unbearable representations of traumatic events for the ego. These traumatic representations are characterized by having a symbolic

content. The ego, not being able to cope with these unbearable representations, resorts to the use of defences will use defenses such as repression in order to banish them from conscious awareness. Consequently, The ego's affect is strangled depending on the type of neurosis. In the case of hysteria neuroses this affect is manifest in the body.
According to Verhaeghe (2005, p496) "*symptoms in psychoneurosis posses a meaning that can be interpreted and understood*."

Nevertheless, in actual neurosis there is an interaction between sexual excitation and a "*failure of psychic elaboration*" (Sloate, 2016, p5). The cause, according to Verhaeghe (2005), is linked to an "*inner tension of the drive*" and to the incapacity of the drive to elaborate in a physical way. In terms of the drive, Freud referred to a *"border concept between the somatic (source and pressure) and the psychic"* (as cited in Verhaeghe, 2005, p497). The outcome of this inability is, according to Geyskens, *"primary anxiety and/or somatic equivalents of anxiety"* (as cited in Verhaeghe, 2005, p497). There are three types of actual neurosis: anxiety neurosis, neurasthenia and hypochondria.

Freud (1893-1899) asserted that patients with actual neurosis do not have the capacity for symbolic representation. Furthermore, he claimed that the symptoms are solely somatic and therefore do not have a symbolic meaning and they cannot be interpreted. Freud believed that actual neurosis was not suitable for psychoanalytic treatment insofar as the lack of meaning embedded in its symptoms would make them unanalysable. This is why Freud focused his studies on psychoneurosis and not actual neurosis.

2.4 Hysterical neurosis

Sloate explains that Freud saw hysterical symptoms as forbidden unconscious wishes that are "*represented by symbolic substitutes"* (Sloate, 2016, p2). In hysteria, the physical symptoms are symbolic representations of phantasies that are not conscious for the patient. Furthermore, Freud believed that psychosomatic illness is produced and sustained by "*intrapsychic conflict"* (Sloate, 2016, p13).

Breuer and Freud (1893-1895) in their investigation of the causes of hysteria, used the method of hypnosis, as part of the Cathartic method, in which the patient remembered repressed memories. In this process, the patient was able to recall memories that caused the symptoms in the first place. For Breuer there was a trauma at the heart of the symptoms and he thought that it could be of an external nature, a specific event. Later they realised that the trauma can could indeed be of a psychical nature psychological. The symptoms are very disturbing for the patient and they appear in form of neuralgias, anaesthesias in several parts of the body, contractures, paralyses, hysteric epilepsy, chronic vomiting and anorexia, disturbance of vision, or hallucinations (Freud and Breuer, 1893-1895).

These symptoms appear without any biological explanation and can last for years.
Freud and Breuer stated that what provokes the symptoms in traumatic hysteria is an accident, a traumatic experience of the patient. Hysterical patients can manifest hysteria in two ways, which is in attacks of anxiety or in chronic somatic symptoms and sometimes even have both of them at the same time. They found that in each hysterical attack the patient hallucinates the exact event that provoked the first one.

Frequently these experiences, which can be fear, anxiety, shame or physical pain, are events that happened in childhood and later appear in the form of symptoms that can persist even into later adulthood. "*For Freud, pain results from a sudden internal haemorrhage of physical energy*" (Nasio, 2004, p123).

This energy arises and remains trapped within the body. Indeed, traumatic events emerge o manifest as physical symptoms as if the body was able to remember in the present moment that which happened in the past. what happened to it in that moment of time. The symptom is a form of remembering, Freud said the hysteric suffers from reminiscences.

In the famous case of Anna O, the patient had various symptoms like the ones cited previously. In this case history, Anna O's there were two important discoveries; firstly, Breuer deduced that, "*in the case of this patient the hysterical phenomena disappeared as soon as the event which had given rise to them was reproduced in her hypnosis*" (Freud and Breuer, 1893-1895, p35). Secondly, it was concluded that the symptoms seemed to disappear after being talked away. Anna O, one of Breuer patients, called this method the talking cure, in which the patient releases herself of anxious thoughts by talking about them. In fact, , language is used by the patient as a substitute for action.

Furthermore, the hysterical symptoms disappeared when the patient recognised the moment of the original event, the trauma, and with the discharge of its affect. This process of resolving the affect was called by Freud "abreaction" (Freud and Breuer, 1893-1895, p91). For this phenomenon (abreaction) to occur during treatment, the feeling which was evoked by the original event must coincide with the feeling being aroused during analysis.

2.5 Object relations and the important of Affect Regulation

The object relation theory assesses the importance of the connection between the caregiver and the infant in relation to the modulation of arousal in its body. Verhaeghe, Vanheule and De Rick (2007) explain that both Freud and object relation theorists speak about an internal pressure as being what leads to psychic processing. Object relation theory explains that this arousal has to be regulated in the relationship between infant and caregiver. By affect regulation the mother helps the child to acquire a representational identity that "*permits a psychic processing of the drive" (*Verhaeghe, Vanheule and De Rick, 2007, p1339*)*.

The process of affect regulation starts at birth and immediately connects with the external environment and the mother or caregiver. According to Freud, the experience of birth is so stressful and painful that it creates a pattern for all situations that cause anxiety in later life. In such manner, the primeval feelings inherent to "birth anxiety" may be triggered throughout the individual's life (Klein, Heimann, Isaacs and Riviere, 2002, p199). In order to deal with its anxieties, the infant connects with the mother through what Schore (2001, p21) calls "*affect regulation*". Affect regulation concerns the emotional capacity of the mother or caregiver to help the infant deal with the experiencing of arousal. The mother does this by mirroring the baby's internally experience.

The infant communicates its emotions with the mother through the phenomenon of project identification which, according to Segal, is *"a class of fantasy wherein a part of the self is felt to be located in another person*" (As cited in Ogden, 1979, p1); this other person being the primary caretaker, who will process these emotions using her own internal emotional experiences in order to create a response to the infant that conveys *"empathy, coping and*

appreciation" (Wallin, 2007, p49). Subsequently, this response resonates within the baby creating an internalised representation of the mother through which the affect arousal becomes regulated. Moreover, by means of this process of projective identification, the identity of the baby is being formed.

Affect regulation is crucial for the infant's self control because psysically it comes very well equipped with a central nervous system but it does not have the capacity to control it well on its own. The infant needs the mother in order to learn how to master the nervous system; in such manner, the infant learns how to create a pattern in moments of anxiety where the mother attempts to relieve anxiety. After some time the infant will use and transform that pattern as it learns to deal with the anxiety by itself. This relationship with the mother will reinforce a secure attachment.

According to Verhaeghe et al (2007) the goal of attachment is to create a symbolic representational system in which "*affect regulation and the development of a self can come into being*". (Verhaeghe et al, 2007, p1335)

In some cases, the mother is not able to respond to the infant's demands leaving the latter in a state of anxiety. For example, where the infant's outcries are not attend to. In this case the infant perceives that nobody is there or available to fulfill its demands and as a result it might withdraw and develop an insecure attachment.

All stressful situations are very painful for the infant so in order to deal with the external world when the mother is not available, the infant creates defence mechanisms. These are crucial for all human beings and can help to protect against unbearable situations. When the

infant is not able to develop a secure attachment with the mother, it needs to use more of these defence mechanisms in order to cope with painful situations. Infants with a history of insecure attachment have significant risk factors for psychopathology. According to Wallin, "*narcissistic and schizoid problems and ambivalent has been linked to hysteric or histrionic difficulties*" (Wallin, 2007, p23).

2.6 Winnicott and the split of the Psyche and soma

Winnicott stressed that in the relationship between mother and child, it is also important for the mother to help the child achieve personalisation. For instance, when bathing the infant and keeping it warm, the mother helps create an environment in which the infant can get a sense of its body. The repetition of these experiences of body-care builds what Winnicott called "satisfactory personalisation" (Caldwell and Joyce,2011, p83). As a matter of fact, the achievement of a healthy development of the self depends on the balance between soma, psyche and mind.

A failure in the integration of psyche, soma and mind will motivate the infant's creation of defence mechanisms such as dissociation, which is an autoregulatory strategy or "*nonverbal presymbolic forms of relating*" as Schore (2003, p74) called it and it is used by the baby to protect himself against trauma. The consequences of this, according to Winnicott (1949), are that the individual is threatened by overwhelming emotions which are manifested in the body as physical symptoms.

In Leader's paper , "*The Unwanted Child*" (1996), he describes how an infant develops a narcissistic defence because of an insecure attachment with the mother. The narcissistic

defence according to Klein, R (1995) is a defence against the feeling of abandonment in which the object "*projects his generosity and seeks mirroring from the perfect object"*. The ego of the infant, after having been left to deal with overwhelming anxieties, splits. In this split, one part of the psyche, "*tough kid or the parental side*", will take care of the other one "*the dependent kid or vulnerable part*" (Leader, 1996, p140).

Adults that develop this kind of defence in infancy will use the "tough kid" to protect the dependent one at any cost, using depression, psychological symptoms, psychosomatic illness and also destructive behaviours like addiction in order to distract them from unbearable feelings (Leader, 1996, p141). In the narcissistic defence the infant suppresses rage against the mother and also his abandonment grief. This aggression according to Margolis (1994) is turned against himself so that he protects his mother by sacrificing himself. Furthermore, Spotnitz asserted that "*a child who tends to discharge frustration-aggression into his body, is a likely candidate for psychosomatic illness later in life*" (as cited in Leader, 1997, p266).

2.7 Symbolism and psychosomatic disorders

As mentioned previously, Freud assessed asserted that actual neurosis has a lack of symbolic representation and therefore it is not considered suitable for psychoanalytic treatment.

According to Griffies (2016), some patients with psychosomatic disorders do not have the capacity for symbolic function. This means they have a lack of fantasy life and do not use or understand metaphors as well as showing an inability to understand the interpretation of dreams. Therefore, these kind of patients do not respond to interpretations in therapy.

According to Griffies, this is why psychosomatic clients are categorised into two groups "*symbolizing and non-symbolizing mental function patients*" (Griffies, 2016, p53). Griffies (2016) explains that non-symbolising patients have extensive somatic suffering and little psychological distress; they may present with physiological issues such as chronic ulcerative colitis or hypertension. Symbolising patients on the contrary, have little or a lack of somatic suffering and an extensive emotional component; indeed, these patients may present with symptoms such as the paralysis of a part of the body.

Verhaeghe et al (2007) agree with the idea that some patients have a lack of psychic elaboration. Verhaeghe et al (2007, p1322) use the term alexithymia which means "*no words for feelings*". This is the cause of a "d*eficit in the cognitive processing and regulation of emotions*" (Verhaeghe et al, 2007, p1322). They also asserted that research has proven that patients who suffer from unexplained symptoms are predetermined to alexithymia.

This idea has similar aspects to those of object relations theory where the mother helps the infant to regulate its emotions by "*affect regulation*" (Schore, 2001, p21). If the mother has no capacity to regulate the infant's emotions, the infant will not learn to be independent and will continue to show that inability in later adulthood.

Therefore, the continued failure of the early interaction between infant and mother means that the latter the infant is unable to manage or deal with anxiety and overwhelming bodily sensations. Because of this, the infant fails to develop the capacity for symbolic thinking. McDougall (1989) confirms this theory by explaining that the only way that these patients have to express disturbing fantasies and experiences is through psychosomatic symptoms.

2.8 The psychosomatic patient and his treatment

According to Verhaeghe et al (2007, p1336) "*patients with somatoform disorders have considerably more dismissive attachment*". Attachment in the early development of a child is very important for the creation of a "*symbolic representational system*" (Verhaeghe et al, 2007, p1335) that will give space for the development of affect regulation and also for the development of the self.

Wallin (2007) explains that for the client, the therapist offers the potential of a new attachment relationship and therefore a new possibility to develop a symbolic representation system. This can happen by the transferential relationship between therapist and patient. In this relationship, there is place for the repetition of the original relationship where the caretaker failed in the early interaction with the infant. Verhaeghe et al (2007) also asserts that the restoration of this relationship is primordial for the enactment of the "*original bodily arousal into meaningful secondary representations*" (Verhaeghe et al, 2007, p1342).

As mentioned previously, psychosomatic patients, who have a deficit in symbolising do not respond to interpretation. Ann Griffies suggested that they "*required therapeutic interaction that addresses fundamental brain and mind deficits*"(Griffies, 2016, p53). This means that the patient needs to first develop an individualised mind which can symbolize the effects in his body. What is an individualised mind?

Working with these psychosomatic patients, according to Verhaeghe et al (2007), could be challenging. He explains that the profile of this patient is usually described by being extremely perfectionist and having "*a lack of spontaneity, expressivity and flexibility of feelings*". These patients manifest overwhelming separation anxiety and they tend to

dramatise at times when the therapist is not available, such as holiday periods. This anxiety is described by Mitrani as *"the crying of the infant to the mother when confronted with distress and the possibility of her absence"*(as cited in Verhaeghe et al, 2007, p1334).

Verhaeghe et al (2007) assert that these patients are very demanding in their relationships and that they will assume a dependent role also with the therapist which could cause a negative counter-transference. Counter-transference can be experienced by the therapist in a confrontation with the patient as *"changelessness and numbness*" (Verhaeghe et al, 2007, p1334).

Even though counter-transference can be very difficult for the therapist, it is important to contain the different states of the patient before the use of interpretations because, as stated by Verhaeghe et al (2007, p1342) , *"the goal of the treatment is shifting the body memories into verbal representations"*. Before reaching this goal, relational therapeutic interaction can help the patient "*develop symbolizing and mentalizing mind that can find symbolic language for the various arousals, stress and symptoms of their bodies"* (Griffies, 2016, p 55).

The DSM-V, the standard classification of mental disorders, added a new disorder called "*Complex Somatic Disorder*" (Egan & Kenny, 2011). In this disorder, somatic and cognitive symptoms are present and persistent. These patients tend to over-use primary care services and spend a lot of money for these services because they are obsessed with the idea of being unhealthy. General Practitioners find this type of patients very challenging because of their continuous and obsessive help-seeking behaviour. According to Looper & Kirmayer, a successful treatment normally includes collaboration between psychotherapist and physician

and a practice where *"the patient's physical distress is validated by ongoing medical management"* (as cited in Egan & Kenny, 2011, p95).

Woolfolk and Allen see Affective Cognitive Behavioural Therapy as an effective treatment because it helps the client to reduce "*illness beliefs and symptoms severity"* (as cited in Egan & Kenny, 2011, p95). On the other hand, Asmundson & Taylor propose pharmacological intervention and relaxation training for dealing with somatisation disorder. (as cited in Egan & Kenny, 2011, p95).

2.9 Conclusion

After reviewing several theories related to psychosomatic symptoms, it seems obvious that the majority of these theories conclude that there is a strong relationship to early development in childhood and the relationship between the infant and the mother. In this relationship the care of the caregiver and the role played in reducing or calming anxiety helps the child integrate body (soma), psyche and mind in a safe environment.

This relationship will determine how the infant will manage emotions at that point in its infant life but also in later adult life. The client's incapacity to self-regulate emotions causes these emotions to be manifested in the body in the form of psychosomatic symptoms. Furthermore, some psychosomatic clients do not have the capacity of symbolic function because they have alexithymia, a term which describes a deficit in the cognitive processing and in the client's ability to regulate emotions. These clients do not have the ability to describe their emotions through words.

Therefore, despite of being a very important method for treating psychosomatic symptoms and helping patients express their emotions, Freud's talking cure does not appear to be sufficient for those patients who show a lack of symbolic functioning. This point is supported by the fact that these clients cannot understand interpretations.

Nevertheless, the application of affective cognitive behavioral therapy seems to be very beneficial for these clients as well as relational therapeutic interactions in order to support the development of symbolic function. Methods like mindfulness and body exercise along with close collaboration with a general practitioner have also been suggested as helpful when treating these symptoms.

Chapter 3 Methodology

3.1 Aims and Objectives

The overarching aim of this research is to advance existing literature, and in doing so possibly have an impact on the practice of psychotherapy nowadays. The research undertaken in this study was twofold. Firstly, it explored how somatic pain is currently addressed in clinical practice by therapists. Secondly, drawing from the results of this exploration, it carried out a comparison between Freudian theories and those of contemporary psychotherapy in order to examine if/how they align, overlap and contrast with those theories.

There are numerous methods that can be utilised in research. This chapter will address in detail the methodology selected, from research design to execution, in addition to an analysis of the strengths and weaknesses encountered in such an approach together with a clear plan to address such weaknesses. Moreover, limitations and pitfalls, as well as any ethical implications were addressed.

The following points summarise the specific objectives of the research:

- Establish each therapist's understanding of psychosomatic pain, its most common manifestations where applicable and the therapist's methods of treatment.
- Explore possible causes for psychosomatic pain.
- Identify common themes in the case history of clients who experience psychosomatic pain.
- Explore possible links between psychosomatic pain, disability, and emotional expressiveness.

3.2 Research Design

In order to meet the objective of the thesis, a qualitative style was chosen with questions that McLeod (2005, p 25) would describe as being "intentionally open and loosely boundaried'. Because the topic of study and its practical application via a set of one-to-one interviews is subjective, a qualitative style of analysis met the requirements. Since individual therapists' experiences related to client work and the concepts applied in these settings can be abstract, a qualitative style allowed for more flexibility compared to a quantitative style as it helped to gain insights into each therapist's experience, views and feelings.

A semi-structured interview style was adopted, supported by a pre-written guide that guided. Para no repetir structure the interview process and ensured the interview remained focused on the relevant material. In addition, a set of questions related to key areas of interest was issued to participating therapists.

3.3 Participants

McLeod stressed that if too many participants are recruited it is almost impossible '*to do justice to their contributions in the research report*' (McLeod, 2005). In short, qualitative research is not suited to a large volume of participants. For this reason, five carefully selected participants were chosen with a level of experience and expertise relevant, sufficient and valid for the purposes of this study.

As laid out by McLeod (2005, p32), following a good practice for engaging with potential participants, the individuals were informed about the aim, scope and design of the study in

advance, how much time it would require and the measures taken for maintaining confidentiality.

Participants had to fulfill each of the following criteria in order to take part in the study: therapists had to be fully accredited and current members of either the Irish Association of Counselling and Psychotherapy (IACP), or the Irish Association of Humanistic and Integrative Psychotherapy (IAHIP), or both. In addition, the participants had to be accredited for no less than two years by their specific bodies.

3.4 Materials, Equipment and Procedure

All interviews were conducted face-to-face with each therapist at the therapy centre Insight Matters. The interviews were recorded using a mobile phone, transferred to the researcher's personal computer and then transcribed utilising a software called InqScribed. The duration of the interviews varied between thirty to thirty-five minutes. A hard copy of the interview questions was also offered to each interviewee for their reference.

3.5 Thematic Analysis

The researcher used a thematic approach for the analysis of the transcribed interviews. McLeod pointed out that one of the primary goals of qualitative inquiry is to '*identify themes and show how these themes are linked to each other*' (McLeod , 2001, p145). This approach

was decided as the most appropriate for the purpose of this research due to its flexible, straightforward and accessible nature.

Following the stages of thematic analysis, the transcribed interview material was coded and then examined in order to extract common themes. The results were then examined determine whether they could be organised into superordinate and subordinate themes (McLeod, 2001, p. 146).

3.6 Ethical Considerations

McLeod stressed that it is necessary to give careful consideration to ethical issues at all stages of the research process (McLeod, 2005, p167). Whilst common ethic themes exist pertaining to research of human subjects, there are guidelines specific to counselling research that were considered.

As the researcher conducted the research a common set of issues related to the abuse of power on the part of the researcher can arise (McLeod, 2005, p168). Strategies to deal with these issues include the application '*of appropriate research design, ensuring informed consent and maintaining confidentiality*' (McLeod, 2005, p168).

Appropriate measures were considered in terms of the ethical issues directly related to this study. Each participant was briefed on the area of research and its purpose. A consent form was signed by each participant . The form informed that participants identity was protected

and pseudonyms would be used in all transcripts and research findings. In addition, participants were informed of their rights to withdraw from the interviews at any time and that their participation in the study was on a voluntary basis.

3.7 Limitations

The main advantage of a qualitative study is that it lends itself well to smaller size sample, however, its outcomes are not measurable or quantifiable. Therefore the concepts of validity and reliability, developed for use application in quantitative studies, cannot be applied in the same way for qualitative studies.

McLeod (2005, p35) stated that when selecting data-gathering methods, each method has its own distinctive strength and weakness. Even though face-to-face interviews can be used to generate sensitive qualitative data, '*they are more liable than questionnaires to be influenced by the personality or interpersonal style of the interviewe*r' (McLeod, 2005. p35).

It can also be stated that the '*quality of information gained depends on the level of rapport and trust between interviewer and interviewee*' (McLeod, 2005, p.74). Some participants also might find it intimidating to be recorded. Furthermore, a challenge exists for the researcher to maintain focus on the research task.

Chapter 4 Results

4.1 Introduction

This chapter is focused on the findings of the interviews with five psychotherapists, each from a different psychotherapeutic background. These therapist are specialists in different therapeutic approaches; integrative therapy, psychodynamic, body center therapy, person centered therapy and Cognitive Behavioural Therapy. These interviews explore the psychotherapist's understanding of psychosomatic pain and examine whether these symptoms form part of the therapeutic sessions. Also the interviews explore whether the therapist associates these symptoms with the client's incapacity to express emotions. Finally, participants were asked their views on the best treatment for psychosomatic pain.

In order to find themes and sub-themes in the data collected from the interviews, the researcher has used a thematic analysis. Pseudonyms have been utilised to protect participant identity. The pseudonyms employed are the following: P1, P2, P3, P4 & P5,where P designates "Psychotherapist" followed by the order number of the interview carried out.

The questions made to participants of the semi-structured interview were not closed because sometimes material came up, so were open in order that permitted further exploration of a particular theme. This fact was explained in the literature review. The questions had to be very general and non-specific due to the complexity of the theme of the research , the subject

area is broad and hence it was impossible to cover everything in a way of pre-established questions.

4.2 Psychosomatic symptoms and their causes

Every therapist, from their varying backgrounds reported working with clients with psychosomatic pain. In the thematic analysis, the most common symptoms were: digestive problems, stomach pain, back pain and skin disease. Some participants stated that these symptoms were related to stress, others to the inability to express anger or also related to sexual abuse.

L "what are the most common psychosomatic symptoms you have encountered?"

P1 "Well, there would be things like emm... the most people would relate it in terms of stress, it would be things around skin problems, allergies. There would be things about migraines, things around sinus, congestion" ... "There would be back pain which is quite common" ... "But stress is hugely impacting on that part of the body and in the neck muscle areas and well the back in general".

P2 " I have had quite a lot of clients coming in with the likes off fibromyalgia so it can be anything from joint pain, irritable bowels syndrome and headaches, it can be sometimes similar to anxieties but it is mostly more I suppose internal in a sense of joint pain fatigue ... I suppose for a lot of the symptoms it comes up as palpitations, it is very physically manifested within the body in lot of different ways. Even, you know, rednessnes on the chest, things like that, coming up with particular skin rashes and be it like urticaria".

Participant P4 said that pain symptoms in the stomach were related to anger issues.

P4 "I have three clients right now that come all the time with different pain like this. There is two guys always in pain with their backs. There is one guy that also has pain in the stomach … they all have difficulty to express anger, and the ones who come with a pinch in their stomachs like ibs kind of symptoms, irritable bowel syndrome. I think that if he could express his anger the stomach is getting angry for him because he cannot get angry for himself."

Two of the participants said that some clients with psychosomatic symptoms reported to have been sexually abused in infancy or in adulthood.

P4 *"His biggest issue is that he was sexual abuse, so the abuse happens in the same area that the prostate is. It was a easylink to make".*

P5 "*Yes, I have some clients that have been sexual abused… In the case of this client...It is really difficult for her, she wouldn't let people to be in her physical space. She is really disconnect from her body".*

4.3 The problem of the Medical system and the difficulty working with these clients

Two of the five participants reported having clients in the medical system for very long time. Even doctors advised them to go to therapy. These clients seem to be very difficult to treat because they want to find a physical reason to their complaints. Participants said that it was very challenging to work with these clients because they didn't understand that the symptoms could have a psychological cause.

P2 "I know certainly what happens with a lot of potential clients since they get stuck in a potential medical system. So they get stuck kind of being passed along a cycle through the psychiatric system. So they get stuck in this medical system. Some like the notion of being in that medical system and some obviously don't, it just depends I suppose on their type of personality. I know one particular case of work that I did. The most fascinating was that the particular client didn't want to take any responsibility. So while she was in this medical system and coming here [Therapy] as well, she wasn't taking any guidances, so she was very happy communicating that this was her situation … It can be quite a big challenge to work with people who have psychosomatic pain, who are stuck in that, it can be quite challenging".

L So she had resistance about believing?e that it could be something psychological?

P2 "Huge, huge resistances. Then first I can't say that that is across the board with all clients who have come in,. but the ones that are immediately popping to mind right now, they were probably few that were very resistance... In each case there is two I can immediately think of who would not take any responsibility. So any time they were given a plan, to put a plan in place, whether it was here or whether it was within the medical system they would push against it constantly and find excuses why the couldn't. And they didn't like if people questions it".

P3 " A classic client example, It is one that I use when talking about this kind of issues in a teaching context would be a client, a man in his forties who came to me because he had a lot of pain for physical symptoms: headaches, chest tightness and pain, dizziness, tension in various muscle groups, shoulders for instance, and he found it very hard to... like he went to various doctors to get this checked out and he founded very hard to accept that they were

saying they couldn't find any physical causes, and he was saying there has to be a physical cause. Then he was referred for counselling on the assumption that this was probably more anxiety related. But again he found that hard to accept, It took a few sessions of information on psycho-education and discussion and explanation for him to even begin to accept that that was an adequate explanation".

L "He refused to believe that it was psychological?"

P3 "Yeah! he found it really difficult to imagine that that could possible be true. He was saying: "but the pain can be really bad like how could it just be due to things like anxiety, there must be a physical cause, maybe they hadn't found it yet", and that's why he went to a few Doctors but after he found a few Doctors they just said: "we can't deal with this anymore you have to get this checked out by somebody who deals with the psychological side of things".

L "So you have to work with a lot of resistance?"

P3 "A lot. Yes, in this case yes. And understanding that if you don't understand your symptoms you will get anxious about them and that can lead to further symptoms, even panic attacks. He was initially quite resistant to that".

4.4 Psychosomatic and the link with the incapacity of the client to regulate emotions

All participants agreed that clients with psychosomatic symptoms have difficulties in regulating emotions. Participants P4 and P5 were more specific and explained that one of the most difficult emotions to deal with for psychosomatic clients was anger.

L "You think that sometimes psychosomatic pain is linked to not being able to regulate emotions?"

P2 "Yes, this is a kind of an interesting side... I would be a firm believer that the body remembers. And that in the fact that trauma, whether ?is incremental trauma, that absolutely the body would hold on to experiences if it didn't have the opportunity to be vocalize or explore. If it has not been worked through it does get stuck in the body".

L "So do you think that there is a link between psychosomatic pain and how the person regulates his emotions?"

P3 "Aw very much, absolutely. I mean emotions are very somatic, they are not just mental. Emotions are a very interesting thing for that reason. Our emotions are part of our mental life or a part of our somatic life, both I think. In a way it makes them interesting. So that whole question about how some people particularly, people that we are meeting in therapeutic room haven't learned to relate well to their emotions or certain emotions. But it is an interesting question how does anybody learn to relate to emotions, that whole developmental question is an interesting and complicated".

For participant P4 the idea of psychosomatic symptoms being linked to the difficulty in regulating emotions, was clear from the beginning of the interview.

L "What is your understanding of psychosomatic symptoms?"

P4 "My understanding is that sometimes an emotion that cannot be expressed would manifest in the body".

L "So you think that could be a symptom of how some people cope with emotions?"

P4 "they all have difficulty to express anger, and the ones who come with a pinch in their stomachs like ibs kind of symptoms, irritable bowel syndrome. I think that if he could express his anger the stomach is getting angry for him because he cannot get angry for himself."".

P5 "Yes, I think so. Some people get quite angry, and I have seen in some people that this kind of anger can be stored in their hips".

Participants were asked if the relationship between therapist and client was important in order to help the client regulate emotions. They all agreed that it was very important except for participant P1.

L "Do you think that the relationship between therapist and client is important in order to regulate client emotions?"

P1 "I can't see that it is me regulating the client ... I distinguish the differences between those and counselling for me is: you have a specific problem, you know what it is and you have a timeline. So you do a counselling process. Where psychotherapy is much more a long term and It is acknowledged as such and it needs to minded very very carefully and it needs to be minded at the peace of the client is able to do it"

4.5 Body and mind disconnection and the use of mindfulness in the sessions

Some of the issues mentioned in the interviews were that clients with psychosomatic symptoms seem to have no awareness of their body. For this reason, there was some controversy in terms of some participants reporting the use of mindfulness techniques in order

to work with body symptoms because it helps the client connect with the body, whereas other participants said that it was very difficult to use body exercises with these kind of clients precisely because of the client's incapacity to connect with his body.

Participants P1 and P4 said that the use of mindfulness in their session is very useful to treat body symptoms.

L "when there is a representation of a pain in the body in one of your sessions, would you use any kind of technique?"

P1 "I would do it relative to what I am hearing, so for example, It is very often for me to use mindfulness, I think that this is extremely useful process".

L "Do you think that mindfulness helps the client to bring awareness to his/her body?"

P1 It absolutely does because you're bringing them into the present moment..

L "How do you treat clients with psychosomatic symptoms?

P4 "The best example I can give you is the guy with the stomach pain. And yes what I do is to bring some awareness. How they are feeling and try to get in touch with how they feel around the stomach pain, they focus in this and then I try to focus is there any emotion there and then I just explore what thoughts they start to have, like kind of free association. But yes, just that get them to focus".

Participant P2 and P5 reported that some clients find body work difficult and that the process can be very slow due to the separation they have between body and mind.

L "Do you think that clients with psychosomatic pain have their mind and body separated?"

P2 ""Yes, I think it is very separated and how they process is very different. Some would be much more in that mind space and other are much more focused and you can actually almost see it physically"".

L "And when the symptom is represented in the session, do you use any exercise like mindfulness, or body exercises something that the client can pay attention to the body?"

P2 "Yes, I suppose again with different clients I do different things, depending on what works for them. I did do some relaxation exercises and mindfulness exercises with this particular client but she could sometimes, again, push back with that. She wasn't keen to go there. She wasn't keen to actually listening to her body. She could tell me all about it, all about her symptoms but when it came to actually listening to her body, not so much."

L "She was disconnected from her body?"

P2 "Massively, yes. Very bright intelectual client but everything was stuck in the body. And she tried to rationalize"

L "Do you use exercises like mindfulness or relaxation exercises in your sessions?"

P5 "I think it is used as a way of control your mind or a way of trying to distract yourself from stuff. When it's actually about noticing of stuff and not distracting from. And so yes I would use mindfulness a lot ... I think mindfulness comes more into attuned of what's going ... So to be able to say actually my chest is sore, or my left knee is sore today, and then just notice that and then you can start to work with that. Because I think for people just to identify

where the pain is it can be really hard. I think kind of appreciate it much more over the last few years, how difficult that work is".

L "So you think that could be difficult to work with psychosomatic symptoms?"

P5 "I think it is slow maybe ... yeah, I think it is definitely slow. I suppose as therapists we try to take everything into account. Now you are wondering how the person's relationship are, if they are come with anxiety, if they are feeling pain in their body. I suppose there are all kind of different clues. And the more I study or the more I read, the more I realize that the body is such body an amazing way into that stuff . If you can start tapp into it. And I think that is particularly hard for people that are just in their heads all the time".

For participant P3 the use of any technique depends on the stage of the process at which the client is.

L "Do you use mindfulness, body exercises in your sessions?"

P3 "Yeah, I mean, obviously when somebody is in a stage where there is psychosomatic symptoms then some of the intervention of course are cognitive and emotional but some of them are behavioural, you know? Like in the end of it all it is part of the paradox of some of the psychosomatic symptoms is that people worry about them and then they get overly careful about themselves. They think: ok I have a problem so that means I have to be very careful and I have to take it very easy where in fact most of the time they need exercises, paradoxically physical exercises will sometimes really help. And they think that this is the last thing that they should be doing... "

4.5 Working the pre-verbal: creativity and art therapy

Participant P1 explained that the experience of birth, and any subsequent experiences are very physical. Because the infant is in a vulnerable period just aiming for survival, experiences can be very traumatic. The infant has not yet the capacity to develop memories, so the body remembers these experiences in a psychosomatic manner.

P1 "We don't have usually a conscious memory going back earlier than 4 years or even 7 years. "The body remembers", that is the memory back to right into the womb. So giving that research shows us that within 12 to 13 weeks in the womb ... the foetus is responsive to an external stimuli of vibration. So that first stimulation that they see the foetus being responsive to an external [stimuli] ... when the child is born that they place here at the chest, the breast so that they can in this traumatic experience of birth, our first trauma experience, the child has a sensation of "aw I'm familiar with that feeling and I'm familiar with that hearing. So It has a somewhat calming effect on the child. And that is really important. So when we develop that process we are not born feeling as kids, as babies, during the non-verbal period. We are of course functioning but we are so busy primed to simply survive that we don't have space for memory and it's not important to us. We don't have that until all the other stuff is done which is to survive and to have the tools given to us by our parents hopefully and by the external environment to survive. And that is why they are the places where I believe most of our trauma happens which is psychosomatic".

P2 and P4 stated that they work the preverbal stage by using art therapy in the sessions

P2 "But yes I do think that there potential was trauma. And we tried to look at it, I tried to be as creative as possible with her. Because just sitting and talking didn't always work. So I would have used a lot different ways of working with her, like drawing was a big one for her. A lot of memories did come up through the drawing, which was really interesting. And even going through photos was another one".

P4 "I don't think is always about verbalized them (emotions). I also encourage them to do something creative, like painting, poetry. The client that I spoke before that had this problem with the prostate, he started in the last 3 months doing poetry and he comes in and then he read me a poem".

4.6 Client's Referred to psychotherapy by General practitioners

Participants were asked if they got referrals from GPs of clients with psychosomatic pain and just participant P3 said to have received referrals from GPs. This psychotherapist is Cognitive Behavioural Therapy oriented.

However, participant P2 explained that normally GPs encourage the psychosomatic clients to attend CBT therapy.

P3 *"Yeah, definitely some they do, I work a lot with areas like depression, anxiety and addictions things like that and I work a lot from a cognitive behavior perspective so I guess quite a lot GP referrals. One of the most common reason that I get referrals from GPs, or*

even occasionally Psychiatrist, is because there is physical symptoms that don't seem to have biological cause"

P2 "*When they get stuck in the medical system ... the medical system is very general, It's not that they don't have compassion but they work of a medical model. It is very different, it is very much task orientated. Hence why CBT, a lot of the medical organization encourage CBT"*

Chapter 5 Discussion

5.1 Introduction

During the interviews, all of the participants confirmed that, in their experience, psychosomatic pain is linked to the inability to regulate and express emotions. The majority of the participants concluded that anger was the most difficult emotion to express for those clients with psychosomatic symptoms. Furthermore, the majority of the participants said that the use of art in the sessions helped these clients to express emotions when attempting to speak about them proved impossible.

5.2 Psychosomatic symptoms and their causes

The literature review does explored the most common symptoms of psychosomatic patients. However, it was very interesting to find that in the data collected all participants report a very similar symptomatology in their clients. In most of the cases the symptoms manifested were; digestive problems, stomach pain, back pain and skin disease.

According to the participants, these symptoms were associated to stress or to the inability or express anger.

As stated in the literature review, for Margolis (1994) the infant, suppresses rage against the mother and turns it against himself as a narcissistic defence. According to Spotnitz "*a child who tends to discharge frustration-aggression into his body, is a likely candidate for psychosomatic illness later in life"* (as cited in Leader, 1997, 266). This could explain the

inability of some clients to express anger and their developing psychosomatic symptoms as an aggression to their body.

Two participants reported having clients with psychosomatic symptoms who had suffered sexual abuse. In these cases the abuse seemed to have happened during infancy. According to Freud (1983-1899) there are two types of neuroses related to psychosomatic symptoms with different etiologies, these are psychoneurosis and actual neurosis. In psychoneurosis there is a sexual aetiology of infantile nature and in actual neurosis there is a sexual aetiology of actual sexual life.

Participants didn't use terms like psychoneurosis or actual neurosis, but these findings could perhaps link to Freud's theory of the aetiology of psychosomatic symptoms even though further research should be done.

5.3 The problem of the medical system and the difficulty working with these clients

Interview findings show that clients with psychosomatic symptoms find themselves in a vicious circle in which they try to find a medical reason for their pain by constantly seeking medical help. When doctors do not find any biological cause and suggest psychological help, these clients still find it very difficult to believe that doctors cannot find a cure and so may have much resistance to therapy.

These findings resemble the DSM-V description of the mental disorder called *"Complex Somatic Disorder"* in which somatic and cognitive symptoms are present and persistent (Egan & Kenny, 2011). As mentioned in the literature review, these clients over-use primary care services and spend a lot of money because of their obsession with the idea of being unhealthy.

According to Looper & Kirmayer (2001) clients with this disorder are considered very challenging by General Practitioners because of their continuous and obsessive help-seeking behaviour.

Findings in the interviews also show that for psychotherapists these clients are difficult to treat. Participants in the interviews asserted that clients with psychosomatic symptoms seem to have a lot of resistance to therapeutic treatment because they resist the idea that the reason for their pain can be psychological. Also, one of the participants said that some psychosomatic clients have difficulty taking responsibility for themselves and that they are always looking to being taken care of. Verhaeghe et al (2007) assert that these clients would assume a dependent role with the therapist which could cause a negative counter-transference.

5.4 Psychosomatic and the link with the incapacity of the client to regulate emotions

This part of the interview was very clear for participants that agreed that psychosomatic pain is related to the client's capacity to regulate emotions. The findings coincide with the research in the literature review. There is a concordance between psychosomatic symptoms and the ability of the clients to regulate their emotions. According to Verhaeghe et al (2007) clients who suffered from unexplained symptoms are predetermined to alexithymia, which means that they cannot put into words their feelings. Verhaeghe (2007) explained the cause of alexithymia is a *"deficit in the cognitive processing and regulation of emotions"* (Verhaeghe et al, 2007, p.1321). Participants did not use the term alexithymia but they explain the difficulty of psychosomatic clients to put into words their feelings and also their difficulty to regulate their emotions.

In addition, participants mentioned the difficulty of clients to put their anger into words . Anger seems to be one of the most difficult emotions to express for psychosomatic clients.

Findings show that the majority of the participants agreed about the importance of the relationship between therapist and client in helping the client regulate emotions, most of them said that the relationship was key to working with their clients. These findings agree with what Griffies (2016) explains about the relational therapeutic interaction in that it that can help the patient "*develop symbolizing and mentalizing mind that can find symbolic language for the various arousals, stress and symptoms of their bodies"* (Griffies, 2016, p55).

5.5 Body and mind disconnection and the use of mindfulness in the sessions

As mentioned in the literature review, Winnicott (1949) explained that the infant uses defence mechanisms like dissociation in order to protect itself from overwhelming emotions which are manifested in the body as physical symptoms as the result of a failure in the integration of psycho, soma and mind. This defence mechanism continues to be used in later adult life. This resembles the findings in the interviews where the participants confirmed that clients with psychosomatic symptoms seem to have separated body and mind.

Participants find it very difficult to bring an awareness in their clients about their bodies. Some of the participants said that techniques like mindfulness helped the clients to reconnect with their body. Moreover, other participants asserted that it was difficult to conduct body exercises because their clients were too disconnected from their bodies and so such attempts did not work. The majority said that it was a very difficult and slow process to reconnect clients with their body due to the disconnection of body and mind.

So, in conclusion, mindfulness and body exercises are not useful for all patients with psychosomatic symptoms and it depends on the particular capacity of each client to reconnect with their body.

5.6 Re-working the pre-verbal: creativity and art therapy

It was very interesting to find that the majority of the participants said that creative work in the sessions, such as painting or any kind of artwork, helped clients express their emotions. Schore (2001, p74) called the defence mechanism of dissociation *"nonverbal presymbolic forms of relating".* By doing something where language is not needed, these clients are able to express their emotions and do not need to use defence mechanisms like dissociation as normally happens when using mindfulness exercises or by trying to express emotions by through speech.

According to Verhaeghe et al (2007) *"the goal of the treatment is shifting the body memories into verbal representations".* But as mentioned in the literature review clients who suffer from unexplained symptoms are predetermined to alexithymia, which means they cannot put their feelings into words. Therefore, these clients firstly have to develop the capacity for symbolic representation before they can express their emotions into words.

According to Wilson (1985, p88) "*Artwork promotes the development of the capacity to symbolize and that this capacity is linked to a number of critically important ego functions".* Therefore, art therapy and the relationship between therapist and client can help psychosomatic symptoms. Lacroix, Peterson and Verrier (2001) asserted that *"The opportunity to discuss the problem presented by the patient, and to be supported through a*

*consistent positive relationship and supply of art material, offers reassurance"(*Lacroix, Peterson and Verrier, 2001, p21).

Furthermore, Wallin (2007) asserts that the figure of the therapist offers the prospective representation of a new attachment for the client and that in the transferential relationship there is a place for the enactment of the original relationship with the mother or caretaker. According to Verhaeghe et al (2007), the restoration of this relationship between therapist and client is primordial for the enactment of the *"original bodily arousal into meaningful secondary representations"* (Verhaeghe et al, 2007, p1342).

5.7 Client's referred to psychotherapy by General Practitioners

Findings show that just one participant, who was a cognitive behavioural therapist, gets psychosomatic clients referred from GPs. Other participants confirmed this by stating that medical organisations encourage clients with psychosomatic symptoms to attend cognitive behavioural psychotherapists.

In The Irish Psychologist Journal, an article called *"Somatization disorder: what clinicians need to know"* (Egan, Jonathan; Kenny, Maeve, 2011) explains, just as the title says, what GPs need to know about Somatization disorder. This disorder is defined in this article as being *"characterised by at least four unexplained pain symptoms, two unexplained non-pain gastrointestinal symptoms, one unexplained sexual or menstrual symptom, and one pseudo-neurological symptom"(*Egan & Kenny, 2011, p93). The only two psychological treatments that this article advices for clients with this disorder are Cognitive Behavioural

Therapy and Affective Behavioural Therapy insofar as *"CBT helped to reduce patients' illness beliefs and symptom severity" (*as cited in Egan & Kenny, 2011, p95).

Chapter 6

6.1 Conclusion

This research shows that there appears to be a causal link between early experiences in childhood and psychosomatic pain. The primordial relationship between the infant and the caretaker is crucial for the mental health of the child. In the earliest developmental stages the infant learns how to self regulate arousal when dealing with stressful situations. When the infant does not develop this capacity there are be consequences in adulthood. One of the consequences might be the non-capacity for symbolic function, so for the person it might become difficult to express emotions through speech so that they resort to express themselves in the form of bodily symptoms.

According to the findings in this research, the first step in therapy with clients who have psychosomatic symptoms concerns the awareness of the psychotherapist in terms of what the client's capacities are. For some clients it is nearly impossible to express emotions through speech because they do not have the capacity for symbolising, meaning the capacity for psychic representation. So other types of approaches will be needed, such as art therapy or any activity where language is not the main tool. For these specific types of clients the first aim of therapy is to help them develop the capacity to symbolise, so that after certain interventions they can put emotions into words and it seems that art therapy helps in this process.

For other clients body exercises and mindfulness seem to work to reconnect body and mind and impacts on bodily symptoms because they now have the capacity to symbolise and express in words emotions and express what is happening in their body.

But what seems crucial is the relationship between therapist and client by which the client has the opportunity to re-enact the original event through the relationship with the therapist. Some participants reported to have psychosomatic clients who had suffered sexual abuse.

But even though the relationship between therapist and client is so crucial, findings also show that clients with psychosomatic symptoms seem to be very difficult to treat psychotherapeutically , so they tend to be resistant towards therapeutic treatment and have difficulty taking responsibility of taking care of themselves which can make it very difficult for the psychotherapist to establish a relationship with the client.

Therefore, there is a lack of a working relationship between medical services and those who offer psychological treatment for these clients. If General Practitioners were more informed about different treatments, it would be easier for these clients referred by GPs to find an approach that works for them.

6.2 Strengths and Limitations

The strengths of this research pertains to the information collected regarding psychosomatic symptoms. There are many articles and books about psychosomatic pain and also many interesting theories. This topic very important for practitioners to know about when working with clients.

The limitations were mostly in relation to finding therapists to take part in the interviews. Many emails were sent and just two people answered. When some psychotherapists were contacted on the phone they reported not to have time or not to be familiar with the topic because they did not work with psychosomatic pain in their sessions.

Also it was impossible to read all of the information available about this topic, and therefore a selected reading list was summarised for the purpose of this research.

6.3 Recommendations for Further Research

It would be very interesting to explore the information that the GPs have about psychotherapy treatments for patients with psychosomatic symptoms. It seems, from the data collected in the literature review that they do not appear to have sufficient knowledge about therapy other than CBT. It would be easier for these kind of clients if the GPs were more informed about different therapies.

On the other hand, it would be also very interesting to continue research into how art therapy is beneficial for clients with psychosomatic symptoms. Further research would give a better understanding as to how art therapy can help develop a symbolic function capacity in these clients.

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Appendix I Consent Form

Dear _____

My name is Laura and I am currently studying at DBS School of Arts, Dublin, doing a BA in Counselling and Psychotherapy. I am in the process of writing a Thesis on:

Psychosomatic Pain

Therefore I am looking for Psychotherapist to participate in a short interview lasting no more than 30 minutes. The interview will be recorded and transcribed. You can request a copy of this interview, once transcribed. (This process can be completed face to face or over the phone, whatever suits you best.)

Please note that the information from the interview that you provide will be shared among my colleagues and with anyone who wishes to read this Thesis. However your personal information will remain anonymous and no one will be able to trace the information back to you. Your name will not be requested during the interview.

You can also freely withdraw from this research at anytime. All information provided will be stored securely under the Data Protection Act. Please sign below if you give consent for the interview to occur and we can arrange a time and date that suits you.

Thank you very much for your time. I really appreciate it.

Contact details

I, _____, give permission for Laura Bustarviejo to use the relevant information in her/his research. I am aware that I can withdraw at anytime and that all information will be protected under the Data Protection Act. I am also aware that I will remain anonymous throughout this process.

Signed: _____

Appendix II Interview Questions

Psychosomatic symptoms: a contemporary psychotherapeutic exploration

Psychosomatic symptoms are those that do not have a biological explanation.

These symptoms could be caused by a **dysfunction in the emotional** life of the client or by a **traumatic event** that has not been addressed. The goal of this research is to explore the questions as to whether clients present with psychosomatic symptoms, and if so how they are treated in therapy. In addition is it the case perhaps that such symptoms manifest during a therapy and if so, how are they managed by the therapist. These questions will be explored by interviewing therapists from different therapeutic backgrounds.

- What is your understanding of psychosomatic symptoms?
- Do clients you receive present with pain conditions?
- If so what are the most common psychosomatic symptoms you have encountered?
- How do you treat with these clients ?
- Do you have any clients referred by a general practitioner due to the manifestation of psychosomatic symptoms?
- When the client, in the course of a therapy, complains about a persistent pain, do you advise them to seek medical intervention?
- In your experience is there a particular family history or dynamic common to such clients?
- What in your opinion causes psychosomatic symptoms?

- Do you think that there is a link between client's difficulty to express emotions and psychosomatic symptoms?
- Do you use any complementary techniques like mindfulness, relaxation, meditation in your sessions with the client?