

# ***an exploration into the relationship between visualisation, somatised pain and the unconscious***

**Robert Shaw**

**I**n my practice as a registered osteopath, which now also incorporates some counselling, I have started to use the technique of visualisation. The theory I use is that unconscious undischarged conflict may be represented within the body as somatised pain. This pain is conveyed to consciousness by means of pain pathways; at the conscious level the pain may be visualised.

## ***visualisation***

Literally, visualisation means being able to call up an image, to see that image although it is not present at that time to see. It is unlike vision which is "the construction of efficient symbolic descriptions from images of the world" (Marr, 1980), in that we can create images from the construction of our own internal symbols. However, both require the same brain circuitry and are, therefore, very similar. Indeed, our internal images are, no doubt, based on our view of the external world and how we have reacted with it.

The use of imagery is an ancient healing tool. Shamanism, which dates back 20,000 years, uses imagery in conjunction with hallucinogenic drugs and deep meditation to try to encourage healing (Achterberg, 1985).

The process of visualisation is intriguing. We can see experiences past, present and future. We can relive moments. Our sense of sight is evolutionarily very well developed, so it is probable that our sense of insight is a concomitant. Indeed, many of our phrases highlight this sense, e.g., "I see what you mean", "Imagine a scene", "I'll put you in the picture", "What's your point of view?", etc. In effect, we internalise sight by imagination. The term insight probably arose from this ability.

Classical mythology often provides us with characters who symbolise these concepts. In this case it is Tiresias, a prophet who was given the gift of insight by the god Jupiter. The character Tiresias was used to demonstrate this ability, by T. S. Eliot (1962) in his poem *The Wasteland*:

*I Tiresias, though blind, throbbing between two lives,  
Old man with wrinkled female breasts, can see...*

*I Tiresias, old man with wrinkled dugs  
Perceived the scene, and foretold the rest—*

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Robert Shaw is a Registered Osteopath, working in Derby and Ashbourne, and has also completed the Advanced Diploma course in Counselling at Derby University.

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Tiresias, although blind, can see, he can perceive. He does not need to be present in order to see, he has insight.

We may not all be able to prophesy, but we can all see images which are not real in the sense that they are tangible and in front of us, but they are real for us in that we made them.

The influence of these images can be very strong, so that, "the nervous system cannot distinguish between a visualised response and an actual one" (Weber, in Wilber, 1985, p.211). This is one of my assumptions, i.e., the body reacts to internal images as if they were real.

The cerebral cortex appears to be where we generate thought. It also has a role to play in our response to the environment. In fact, the control of the cortex is global, since under hypnosis we can inhibit reflexes such as corneal (blink reflex) and gag reflex. These very primitive reflexes are considered to be under the control of the brainstem cranial nerve nuclei, yet they can be over-ridden under hypnosis by higher centre or cortical control. The implication here is that "there are no reflexes" (Randell, 1992) and that all so-called involuntary control can become under the influence of conscious thought. Hence the process of biofeedback and the ability to slow one's heart, metabolism, etc. Therefore, "the power of thought can be so great that one can think oneself into illness and into health" (Weber, in Wilber, 1985, p.211). This is obviously of great importance in the realm of psychosomatic illness.

## **somatised pain**

Put simply, this is pain present for no medically proven cause; that is, people with somatised pain have no evidence of organic disease. In the USA, conservative estimates of ten per cent are given for purely physical medical services devoted to people suffering somatised pain (Ford, 1986). The number of people treated with psychiatric methods is not included. Indeed, as Goldberg and Bridges (1988) point out, "the high technology surrounding medical training encourages doctors to seek reductionist explanations of pain and distress". Pain is personal and real for the person concerned. However, if it doesn't fit in with the paradigm of the practitioner it remains untreatable or, worse, considered unreal. I feel in my own practice that many symptoms are due to somatisation.

## **psychological trauma**

My next assumption is that an unconscious conflict, a psychological trauma past or present, may erupt in the soma as pain (Reich, 1983, 1990; Frankl, 1990), that is, the somatised pain acts as a defence, and that the greatest defences have most concentration of libido (Randell, 1992).

Freud (1949) defined the unconscious as mental material and mental processes which have no easy access to consciousness but which may be inferred, discovered and translated into conscious form. In a way, consciousness is the tip of the iceberg, with the body of the iceberg

representing the vast array of unconscious dynamic processes. One of these processes may be somatisation. When a conflict within the unconscious can no longer be contained, the muscular body armour (Reich, 1983) becomes so tight it causes pain. This somatised pain becomes a localised area of unconscious conflict, made aware to the conscious via pain pathways. The topographical representation may not be significant as processes of repression and dissociation are probably present, but the pain is of significance. However, our culture teaches us to seek out a physician to alleviate the pain; if unable to find a medical cause, the patient has a problem, for the pain is real for the sufferer, but not for the physician. This raises an interesting question for our society and for patients with pain, i.e., whose pain is it?

## *imagery and the brain*

Imagery is preverbal: before we are able to speak we communicate by bodily movements, sound, gestures, facial expressions (Frankl, 1990). This is preverbal communication. However, prior to language all communication was preverbal, but image-formation must have been present before words. We think by visualisation (Achterberg, 1985; Pratt et al., 1988) and the processing of images is a precursor to speech. Also, there is evidence to suggest that nonverbal images are a speciality of the right cerebral hemisphere, hence when parts of this hemisphere are damaged people have a problem identifying parts of their body to which it relates (Achterberg, 1985; Sacks, 1984). An implication here is that body sensations are converted into imagery primarily in the right cortical hemisphere, and that this imagery is a primal form of communication; this may be the mechanism by which the unconscious communicates to the conscious, and is "literally the stuff of dreams" (Randell, 1989).

The mechanisms involved require a little explanation using some basic neuroanatomy. The neocortex includes right and left cerebral hemispheres. It is termed "neo" because it is thought to be evolutionarily more recent than other areas of the brain. This part of the brain is highly developed in us and, although its areas have been mapped out according to their functions, e.g., motor, sensory, auditory, visual, etc., the way in which it works is poorly understood, although there is a growing acceptance that its operations are modified by a myriad of feedback mechanisms, aided by vast numbers of intercommunications, and that it has a plasticity of function (Altman, 1987). Karl Pribram (Wilber, 1985, p.2) has put forward the idea that the cortex works like a hologram, so that all parts know the function of all other parts. Hence the recovery from some diseases and accidents where some of the brain is destroyed.

The neocortex has direct neuronal connections to other parts of the central nervous system. I shall briefly mention a few important to this discussion.

Underlying the neocortex at its medial edge is the archicortex, so termed as it was thought to be developmentally old. However, due to the

complexity of some of this region its phylogenicity is now under debate (Hubel, 1979; Nauta and Feirtag, 1986).

The limbic system resides in this area. This system is associated with emotion, fear, aggression and sexuality. It is where primitive discharge zones have been discovered (Randell, 1992). The main components of the limbic system are the hippocampus, so named because it looks like a seahorse, and the amygdala, which is almond-shaped. It is from these two structures that neurons descend massively to the hypothalamus (Nauta and Feirtag, 1986). This is crucial, since the hypothalamus has two great functional activities, one the regulation of the viscera by means of the so-called autonomic nervous system, and two, the regulation of endocrine glands by action of the master gland of the body, the pituitary.

The limbic system is "a recipient of neocortical signals with antecedents in vision, hearing and somatic sensation" (Nauta and Feirtag, 1986, p.128).

Thus the mechanisms and pathways are present to have cortical contact with every system, every gland and every cell in the body. The autonomic nervous system, so called because it was thought to act independently of conscious thought, can in fact be brought under the control of the neocortex.

Visualisation or imagery occurs in the cortex, the content of that image could effect the discharge from the limbic system, and then, by close association with the hypothalamus, affect all bodily processes.

The implication is that one can think oneself into health, or into disease. The use of imagery may well be the link between mind and body, between conscious and unconscious thought.

## Mrs J

A 39-year-old woman, married with teenage children, who originally consulted me for left-sided neck pain of five years duration—two treatments of conventional osteopathy relieved the symptoms. She returned a year later with the same pain. On the second treatment her pain was still the same; she visualised a black pyramid at the misty early part of the day. It was tilted away from her, casting a shadow in which there was a hole. She then imagined herself walking up to the pyramid and she felt frightened, small and insecure. I asked her to try to touch it. She couldn't, as it was laughing at her. I asked her to try and walk away, but she felt fixed and couldn't move. I asked her to look into the hole. There was nothing there. I then asked her how she could make the pyramid friendly. She said by trying to make friends with it. Then she was able to move and turn away. When I asked what the pyramid now looked like, she said it had collapsed, it was flat, all around was clear. The pyramid had lost its colour. Her pain had gone. She exclaimed, "It can't be that simple!". Over the next three sessions, she talked about her problems with her husband, her work and feelings of loss over her father's recent death. Her neck pain did not return.

It would appear that by "looking" at pain a link is made with the unconscious conflict. The graphic description of the pyramid helped in

this process. In this case there was also a dramatic decrease in physical symptoms.

## **Ms K**

A 37-year-old divorcee, currently in a busy full-time job with unsocial hours, and in a relationship with a married man who has a teenage family. Her initial consultation with me was because she had right-sided neck pain with pins and needles into her right arm. Her medical history included recurrent bouts of irritable bowel syndrome, mastitis, frequent night sweats, heartburn and dizziness. She also complained of a rash when exposed to sunlight. All of these symptoms had been investigated ~~unsuccessfully, but no medical reasons had been discovered for her discomfort.~~ Osteopathic treatment improved her neck pain and, as the therapeutic rapport built up, she began to talk about her problems at work and in her current and past relationships. On her sixth visit, the problem with sunlight was worse. She visualised a tingling in the centre, apex of her head; she imagined a grey brain being pulled by rope. After the count of three, she pulled the rope hard, the tingling sensation disappeared. She had no further problems in sunlight, and all her other symptoms decreased. She spent the last five sessions talking about past problems and feelings of anxiety.

In this case, visualisation was used for one session, but seemed to provoke a deepening of the therapeutic relationship and also help in diminishing her symptoms.

In both of these cases, the theme seems to be that visualisation aids the process of achieving some insight into one's problems. It may not be curative or even palliative, but nevertheless appears to help people talk about their problems.

## ***imagery and touch***

Newshan and Balamuth (1990-1991) in their study of the use of imagery and chronic pain, use similar methods. However, the main difference in my work is the physical touching involved. I have been unable to find ~~any recent studies on the use of physical therapy in conjunction with~~ visualisation. Touching the pain by massage or manipulation, whilst asking the patient to visualise the pain, amplifies the signal from the soma to the cortex. This may make it easier to "see the pain". This may also account for the decrease in symptoms that sometimes results, in some cases quite dramatically.

In Newshan and Balamuth's study, the pain suffered by patients was not cured, but patients seemed to accept their pain more, and thus live their lives more fully. Perhaps as in my own patient population, the process of visualisation enables people to look at their problem; this in itself may be a significant step in understanding their pain and thereby coming to terms with it.

Hands-on physical touch therapy in conjunction with visualisation helps to decrease symptoms. An interesting point here is that a part of the limbic system, the anterior cingulate gyrus, has the largest concentration of opiate receptors in the body (Randell, 1992). It may be that tactile stimulation of the soma releases substances like endorphins which stimulate this area of the brain, thereby inducing a relaxed and pleasant feeling, which may enhance the imaging process.

There appears to be more and more interest in somatisation and, as Ford (1986) has observed, "somatisation and anxiety disorders are inextricably woven together".

I do not suggest this approach as a panacea for all ills, but just as the old prophet Tiresias had insight and perception, it may be that the use of visualisation in people with somatised symptoms provides insight and perception into the meaning of their pain.

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