Literature review of somatisation

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".....Communicating personal problems through complaints about the body is the universal language of mankind "
Thomas Szasz [1]

Introduction

Somatisation is a term used to explain how emotional feelings may be expressed within the body, frequently as pain. As such it is an important area for osteopathy to consider. There is a wealth of literature, mainly medical in origin, which sets out to describe this phenomenon. A review is presented in this paper. The pertinence to osteopathy is that we cross the important boundary of the touch taboo - we feel our patients. We provide a form of unconditional support many adults have not received since early childhood.

It is, therefore, important that, instead of searching for the holy grail of biomechanical diagnosis, we look to the mind. In order to do this we must first acknowledge its existence, and then explore the realms of psychodynamics to appreciate that pain can be, and often is, of psychogenic origin. To this end I agree wholeheartedly with Peter Randell[2] who, writing in this journal, said "We must stop the obsessive rummaging amongst the bones and sinews..."

Literature Review

A simple definition of somatisation is provided by Kellner (from[3]) "the presence of somatic symptoms in the absence of organic disease." This seems to imply that if a person in pain cannot be found to be suffering from a demonstrable disease, a pathology, then the pain must be in the mind. This would be acceptable except that "it's all in the mind" is a negative ethic within our society, since it seems to trivialise the pain and, as Peter Evans [4] has said: "(it is) as if the pain and suffering were in some way less distressing to the individual". I prefer the definition of Barsky and Klerman (from[3]), where somatisation is described as "the expression of emotional discomfort and psychosocial distress in the physical language of bodily symptoms". This, at least, allows for some interplay with the psyche, the person in society and his/her body. In this respect Lipowski [5] uses a definition which "refers to experience and communication of psychological distress in the form of physical symptoms". He also accepts that somatisation is "neither a disorder nor a diagnostic category", and further suggests that somatisation "does not imply that the individual displaying it must suffer from a psychiatric disorder", thereby giving the sufferer latitude to remain relatively unpigeonholed, a somewhat unusual stance within the medical model. In general, however, it seems that definitions of somatisation have tried to find a scientific label rather than explore the feelings and emotions which may have a bearing on the pain.

A definition I would put forward is: pain erupting in the soma due to an undischarged unconscious conflict, past or present. This conflict may have been repressed or displaced and, therefore, may not correspond in a linear fashion to the topographical representation of the pain within the soma. Psychosocial elements are important in the construction of the conflict.

For centuries physicians have recognised somatising patients.[5] In the 18th century the labels used were "hysteria" for women, "hypochondriasis" for men, and the generic term "melancholia". However, shamanism, which dates back some 20,000 years [6] has recognised the psychosomatic component to disease. This is, therefore, not a new phenomenon. Indeed, "the tendency to experience and communicate distress in a somatic rather than a psychological mode is widespread in our own and other societies.[5]

The idea that the psyche can be the cause of bodily sensa-

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tions was described by Fenichel:[7] "Any neurotic symptom is a substitute for an instinctual satisfaction; since excitement and satisfaction are phenomena that express themselves in a physical way, the leap into the physical sphere, characteristic for conversion, is in principle not so strange", conversion being the term used to describe how unconsciously repressed feelings become physical pain, which is interchangeable with somatisation.

It is interesting to note that the majority of recent papers on the subject of somatisation are written by medical doctors specialising in psychiatry. This is, perhaps, not surprising when it appears that "Between 25 percent and 75 percent of visits to primary care systems are due to psychosocial distress that presents with somatic complaints." [8] This is a very nebulous figure and very difficult to prove, yet it does suggest a very large number of people who have pain for no medically proven cause. Other authors confirm the ubiquitous presentation of such cases. [5,9,10,11,12]

This raises the question: what happens to these patients? The answer I would suggest is that the current medical model does not appear to help these patients. At present, a person in pain in our society will more often than not make his first port of call his GP's surgery. If the patient persists with the pain and is not reassured by the GP's opinion that the pain is nothing to worry about, the patient may well be referred on for specialist help. This is very likely to be physical help, eg orthopaedic.

Somatisation

Any underlying cause of psychosocial conflict is somehow ignored, and a conspiracy is entered into so that these problems can be hidden behind "the mask of medical problems".[8] It could be suggested that, because of the emphasis on high technology treatments during medical training [13] doctors themselves become somatisers, since they must find a physical cause in order to justify their position. Also, Fisch [8] makes an excellent point regarding the physician in society; "the physician as part of society may perceive a physical problem as more honourable than a psychological one". I would add that doctors, imbued as they are with high status within our society, wield significant power over their patients, and thus may encourage patients to somatise rather than psychologise.

Hence within the current medical model it is not easy for patients to be set down from the medical merry-go-round of GP to specialist, to GP to another specialist, etc. In this respect, osteopaths see patients who are refugees from the system, who have been robust enough to seek a second opinion. However, for most, the medical god proves too powerful and the patient is, by virtue of his symptoms, sucked into the murky world of Descartian dualism and rampaging reductionism. Thus the patient with medically unexplained symptoms may fall into the lap of the psychiatrist, who is able to brandish a formidable array of pharmacological agents at the unsuspecting symptom, since by now the person has been reduced to a symptom, or classified by a syndrome number.

Therefore, psychiatrists probably tend to be the last port of call for medically unexplained symptoms, hence their interest in somatisation. As a group, psychiatrists acknowledge the problem: "a significant proportion of consultations in primary care settings are for complaints which cannot be adequately accounted for by any known organic disease."[11] Yet there appears to be no consensus as to why people somatise. The driving force behind much of the literature seems to be epidemiological, that is the study of disease amongst the population. In one sense this is laudable, in that there is a recognition of the problem and that it is widespread. However, somatisation tends to be looked at from a behavioural point of view as opposed to a psychoanalytic point of view.

The behavioural viewpoint as expressed by Craig et al [12] "focuses on the physical presentation of mood disorder without attempting to explain the association in terms of unconscious defence mechanisms". Presumably it is easier to put a number to a mood disorder than to talk to the person about the meaning of their pain. I feel very strongly that there is a block to the understanding of somatisation. Pain, for any reason, is, by its very nature, unique to that person; it will always be difficult to classify. Also, because of its intimate relationship to the person's body, it will be impossible to measure quantitatively. This pain is experience, the person's experience. It may be possible to try and understand the pain, just as one can try to understand other people's experiences. However, one cannot experience another's life or pain. Therefore, I think the way forward in trying to understand the concept of somatisation is to use "the science of the subjective: psychology" [14] rather than become engulfed by empirical scientific dogma and an endless search for numbers to prove feelings.

There seems a need to reach a basic understanding when one looks at the types of symptoms attributable to somatisation. Craig et al[12] describe how patients went on to become chronic somatisers who initially presented with some worrying somatic complaints, eg, persistent difficulty in swallowing, localised muscular weakness, abdominal pain, pain within the chest wall, and double vision. Other authors have linked somatisation with conditions such as irritable bowel syndrome, headaches, hyperventilation, back pain, pelvic pain and diffuse aches and pains[5,11,15]. Fisch [8] has suggested that

at least 50% of depressives present with some somatic complaint. There seems to be a general consensus that somatisation and depression disorders are linked [5]. Surely this is evidence enough to take these symptoms seriously, for even if they are not the result of some pathological process (in the medical sense), these symptoms are real and have meaning for the person concerned. The meaning of the symptom needs to be explained, not just given a description and arbitrary classification. Psychoanalysis may provide a method for interpreting such symptoms. If one looks at the work of Frankl [16,17] who suggests the psychoanalysis of society, somatisation could be viewed as a symptom of a sick society rather than as a problem for the individual alone. This would be a sea change in thinking for the current experts on somatisation, who view pain as an individual problem, but, I feel, it is one worth looking at in greater depth.

Perhaps the crux of the problem is that somatisation is a cry for help. It is, I believe, the result of unconscious conflict but, in our society, it is considered weak to admit to psychological problems.

In a study by Robbins & Kirmayer [18] they discovered that "subjects report they would be less inclined to visit a doctor for symptoms they attribute to psychological causes than for symptoms they would assign to a physical origin". They also point out that what to do about a symptom is dependent on what one believes to be the cause of the symptom. Since we use somatisation within society as a means to communicate psychological distress rather than openly show psychological feelings [5], it is not surprising we seek the help of a doctor rather than of a psychotherapist. Yet the "commonest way that psychiatric illness presents in developing countries is in the form of somatic symptoms". [13] It is interesting to note that in ancient Buddhism somatisation was recognised as an adaptive achievement. It was thought to decrease psychic pain, replacing it with physical pain for which there was a treatment [13]. I suspect such treatment would have involved physical hands-on therapy of some sort (akin to the latterday osteopath) rather than the high technology drugs and treatments prescribed by today's doctors.

This leads me on to the work of Wilhelm Reich [19,20] who suggested that somatisation was an intrapsychic defence, and the body built up its bodily armour by stiffening the musculoskeletal system. This resulted in pain within the soma due to prolonged squeezing of the muscular tissue, leading to ischaemic muscle pain. These areas of high tone in the body's musculature represented a defence against unconscious conflict. During the 1930s, Reich spent some time in Norway and developed a mode of practice he termed vegetotherapy [21,22], a bodily-centred therapy using a combination of physical therapy and psychoanalysis. He also trained Norwegian psychiatrists and psychotherapists; and, as a legacy of this period, Braatöy (a psychoanalyst) and Bülow-Hansen (a physiotherapist) developed psychomotor therapy in the 1940s and 1950s. The central principles of this therapy were "psyche and soma are indivisible" and "our feelings are transmitted through and reflected by our bodies" [23]. Apart from in Scandinavia these ideas do not seem to have been embraced with much enthusiasm. I find this surprising, since it is generally acknowledged that somatisation is a ubiquitous phenomenon in general health care settings [5,9,10,11,12].

Yet, apart from Reich, no-one has suggested any treatment other than pharmacological. It is as if these symptoms are considered to defy the medical model and must be taught a lesson. As Lipowski [5] has put it "patients with somatisation do not behave as physicians in our culture expect patients to." He also points out that patients are labelled "crocks, turkeys, hypochondriacs, the worried well and the problem patients." It is as if to be a good patient, the patient needs to be properly ill, with demonstrable pathology, a certificate of illness. Also it is necessary to comply with the doctor and accept all the medic says, in other words, to be truly patient.

Some authors, however, try to look with a broader perspective, and link somatisation with the patient's environment as a child [11]; or with the advantages of being ill and the social consequences of decreased responsibility and further secondary gain [5,8,9,11], or even regard somatisation "as a great way for not seeing oneself as mentally ill" [13].

These connections seem only to be paying lip service to the inextricable link between mind and body, psyche and soma. After all, physical complaints are felt in the body, therefore the body should be examined: "Patients with physical symptoms expect to be examined" [11]. However, if a person is labelled as a somatiser, even this examination may be denied. I feel we have to look back to the basic principles of psychoanalysis to examine the basic needs of people since, as Freud said in 1923: "The ego is first and foremost a bodily ego." [24].

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Introducing EGOR

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Osteopaths tend to have the same attitude to research as St Augustine had to sexual restraint "Give me chastity, but not yet." Over the years various political and academic bodies in osteopathy have made general statements about the need for research but found difficulty in going much further into an acceptance of some responsibility for it and then a real effort to bring it about. This ambivalence has tended to hinder people getting involved and translating an initial interest into action; there is also a suspicion that there are many aspects of the benefits of osteopathy not assessable by current research methods.

However, this hesitancy is increasingly challenged. Degree courses, both BSc and MSc, are entering our profession with their obligatory research components. Osteopaths are becoming providers in the NHS internal market, but face a demand for objective evidence of benefit from the administrators they negotiate with. Most importantly the groundswell of curiosity amongst practitioners can no longer be quietened by the suggestion that admission of any uncertainty is somehow disloyal to the profession.