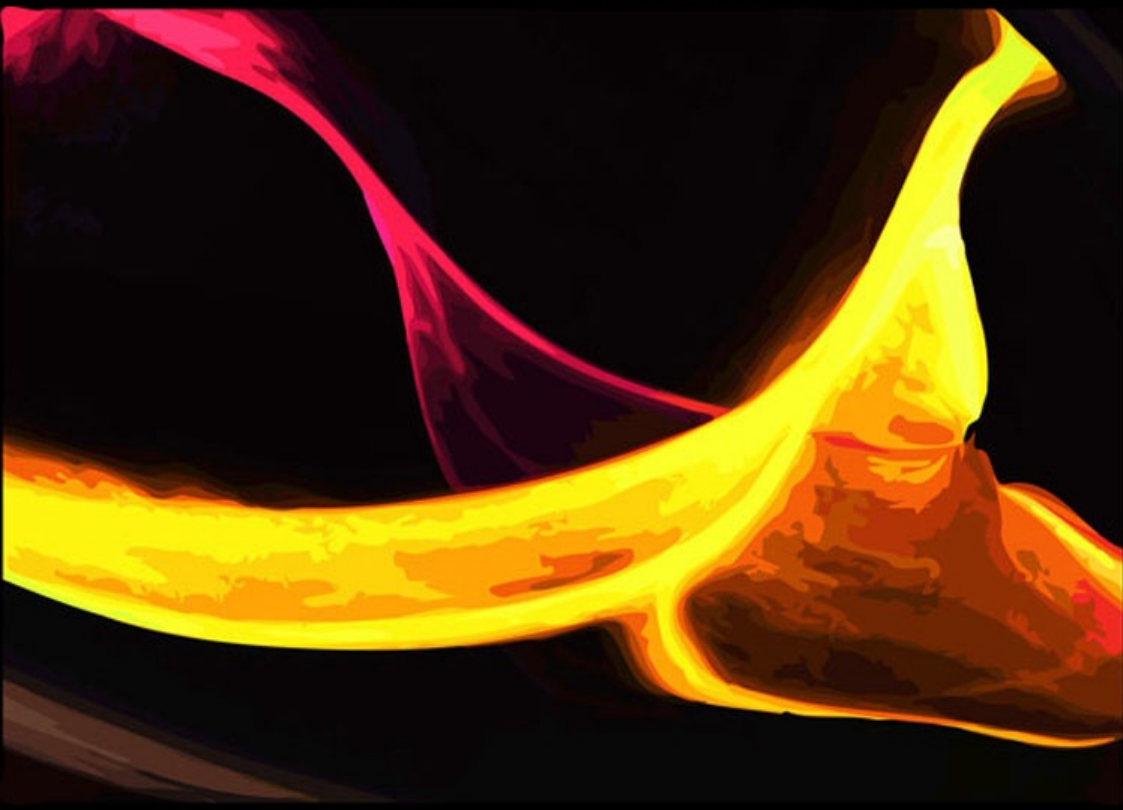
Depressive States and Somatic Symptoms



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Depressive Disorders

Depressive States and Somatic Symptoms

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Depressive States and Somatic Symptoms

KAREN L. LOMBARDI, PhD

DEPRESSION AND SOMATIZATION FROM AN EMPIRICAL PERSPECTIVE

Depressive states, from both phenomenological and symptomatic points of view, often include such bodily disturbances as insomnia or hypersomnia, anorexia, weight loss, loss of energy and libido, anhedonia, psychomotor agitation or retardation, and difficulty in thinking or concentrating. These vegetative signs may move into more elaborated somatic constellations, such as headaches, backaches, or chronic pain, and may involve any organ system: the central nervous system, the peripheral nervous system, or the cardiovascular, respiratory, genitourinary, gastrointestinal, or endocrine systems. Although somatization may be symptomatic of hysteria, anxiety disorders, obsessive-compulsive character pathology, borderline conditions, or grief reactions, many researchers (Katon, Kleinman, & Rosen, 1982a; Lesse, 1967; Lloyd, 1986) suggest that somatization most frequently is represented in affective disorders and particularly in major depression. Somatization is seen as serving the function of masking depression (Lesse, 1967); somatizers do not necessarily present with depressive affect and may instead Find their way to primary care physicians to seek relief for their

presenting somatic complaints (Katon et al., 1982a). As reported in an extensive review of the empirical literature (Katon et al., 1982a), research studies using various depression inventories indicate that when depression is not self-reported, but presents as somatic symptoms to primary care physicians, the diagnosis of depression is missed in more than 95 percent of the cases. Even more importantly, 12 to 35 percent of the patients of primary care physicians are estimated to be significantly depressed.

What accounts for the somatic presentation of affective states? It has been suggested that somatic symptoms are amplifications of normal physiological sensations that become distorted through hyperawareness, hypersensitivity, and selective attention (Lloyd, 1986). Cultural factors, including cultural inhibitions against the direct experience of depressive affect and the lack of vocabulary for emotional expression, have also been implicated (Goldberg & Bridges, 1988; Katon et al., 1982a; Lloyd, 1986). Somatization appears related to increased age, family history, and previous physical illness; it appears to decrease as socioeconomic status gets higher. Symptoms most commonly expressed in depressive patients are those of the autonomic nervous system (sweaty palms, trembling, tachycardia, perspiration, and breathlessness), sleep disturbances, dry mouth, and fatigue (Wittenborn & Buhler, 1979), which suggest an association between depression and anxiety. Some researchers (Burns & Nichols, 1972) suggested a relationship among character traits, family history, and somatization. Several differences were found in comparisons of depressives who had no

localized somatic symptoms to depressives with chest symptoms of nonexertional breathlessness, including sighing respiration and acute hyperventilation; heaviness in the sternum; and depressive themes of preoccupation with death from chest and heart disease. Depressives with chest symptoms tended to be more obsessional, to recall prolonged breathlessness in a parent, and to have lost a first-degree relative within the past three years, suggesting that issues of identification and of loss may be related not only to somatization but to the particular somatic symptoms involved.

In some studies (Goldberg & Bridges, 1988; Katon, Kleinman, & Rosen, 1982b) somatization was regarded as a coping or defense mechanism. In the medical literature, somatization of depression traditionally has been described as an unconscious defensive maneuver on the part of the patient, with the assumption made that intrapsychically focusing on somatic symptoms instead of on an emotion will protect the person from psychological pain. Cross-cultural and historical perspectives reveal that depressives in non-European and non-Western cultures tend to somatize much more frequently, which suggests that somatization is a cultural orientation. Goldberg and Bridges (1988) saw somatization as a basic mechanism of the human species for responding to stress. They postulated that in societies in which the inpidual tends to be submerged in the group, somatization is a relatively common means of expression of stress. In inpidualistic societies, which tend to the narcissistic idealization of the self, somatizing has been replaced by psychologizing, a more recent cultural orientation.

In a study carried out in an urban area of England, Goldberg and Bridges collected groups of psychologizers and somatizers who were interviewed and asked to complete various personality and attitude scales. Interestingly, although psychologizers and somatizers were equally anxious, psychologizers were much more likely to report depression than were somatizers. Given the relationship between depression and somatization, the finding seems contradictory on the surface. However, the authors posited that somatization functions as a defense against blame. Those who somatize tend not to report depression, nor do they see themselves as mentally ill or as responsible for their life predicaments. Inferentially, we might then posit that those who acknowledge their affect, and see themselves as agents in their own lives, somatize less. Goldberg and Bridges asserted that, in somatizers, blame is handled through projection (for example, a Yoruba who attributes his bodily symptoms to witchcraft), through introjection (for example, a hypochondriacal Britisher who attributes his bodily symptoms to undiagnosed cancer), or through a combination of both (for example, a person who believes she has some sort of disease which the doctor has been unable to diagnose, and it's the doctor's fault). Again, we might infer that those who tend more to integrative experience and to a sense of personal agency in their own lives somatize less.

CLASSIC VIEWS OF SOMATIZATION AND DEPRESSION

> The modern term "psychosomatic" disturbances has the disadvantage of suggesting a dualism that does not exist. Every disease is "psychosomatic," for no "somatic" disease is entirely free from psychic influence ....
>
> (Fenichel, 1945, p. 237)

Classic psychoanalytic theory has made some serious attempts to address the mind—body dualism common in Western thought. While continuing to value the development of intellect and the rational mind above more "primitive" expressions of emotional and somatic existence, these attempts have tried to understand the consequences for the human organism of repressing both feelings and thoughts. In classic psychoanalytic theory, somatization was regarded as an unconscious expression, through bodily discharge, of thoughts and feelings that were unacceptable to the inpidual. When an inpidual experienced affect on a visceral level, without awareness of the mental experience, the somatization served as an equivalent for the recognition of the affect. Unlike fully experienced affects, which would be connected to mental awareness, affect equivalents had diminished discharge value to the inpidual, and tended to become chronic expressions of anxiety. Somatization was seen as the bodily result of unconscious attitudes, a substitute outlet for the expression of warded-off conflicts or impulses. For example, the muscular tension that accompanies an unacceptable experience of anger can result in chronic back or neck pain. A woman who develops hives on her chest when wearing a low-cut dress may be expressing conflicts about being

admired and sexually desired.

Somatization, though precipitated by intrapsychic events, utilizes physical channels as a means of discharge. Somatization is linked to regression of the ego, which cannot effectively contain anxiety or neutralize aggression (Schur, 1955). We might, then, see somatization as aggression turned inward or, in more modern terms, as the process of the body attacking the self. Freud (1917/1957) originally attributed somatization to repressed hostility, which emerges either as self-reproach and depression (melancholia) or as an hysterical mode of punishment through the development of bodily symptoms. In either case, at the root of the need for punishment is posited unconsciously felt responsibility for the death, or loss of love, of a loved one.

In an early treatise on the psychosomatics of health and disease, Groddeck (1923/1949) was a proponent of the fallaciousness of separating body and mind. That each continually affects and informs the other, and that the total organism is animated by a life force (the It, which Freud later reformulated as the id) which is expressed through illness as well as through health, is Groddeck's unique contribution. Disease cannot be isolated from the total personality; disease is the It expressing itself through the self.

Groddeck's continued relevance to contemporary thought on psychosomatics is twofold. First, his focus was on the relation between inner and

external life and the continuing relevance of one to the other. In describing the physical treatment of patients, he inquired into the personal function of their symptoms. For example, when an orange peel appeared on a path and led to a patient's breaking his arm, Groddeck investigated what personal purpose might be served through this event. "Since everything has at least two sides, we can always consider it from two points of view, and shall find, if we take the trouble, that for every event in life there is both an external and an internal cause" (Groddeck, 1923/1949, p. 234). Second, he viewed somatization as a defense against rejection and loss. "Thus it implants near the loving mouth which is yearning for kisses a disfiguring eczema; if in spite of that I am kissed, then indeed I shall be happy, but if the kiss is not forthcoming, then it is not because I am unloved but because of the revolting eczema (p. 96)."

DEVELOPMENTAL CONSIDERATIONS OF SOMATIZATION AND DEPRESSION: ANACLITIC DEPRESSION

Throughout early explorations of the etiology of somatization were woven themes of depression and loss. Later work with children, from clinical pediatric (Winnicott, 1936/1978), empirical (Spitz, 1946, 1951; Spitz & Wolf, 1946), and longitudinal case study (Harmon, Wagonfeld, & Emde, 1982) perspectives, provided striking confirmatory evidence of such a relationship. From his pediatric experience, Winnicott suggested that various appetite disorders reached back to the child's experience in the first months of life and became involved in defenses against anxiety and depression. Winnicott was speaking of relatively "normal" or typical children seen in pediatric practice, who developed feeding difficulties as infants or who became anorectic or bulimic or suffered bouts of stomachache or intestinal spasms as young children.

Spitz's work was with children from unusual circumstances—infants in foundling homes who were separated from their mothers and their original family environment for prolonged periods of time. Spitz's original foundling home subjects showed not only severe developmental delays in language, socialization, motor skills, and intellectual functioning, but also severe somatic symptoms, including significantly lowered resistance to disease and higher morbidity rates. Those children who did recover had, on follow-up, a high incidence of eczema and other skin disturbances. Spitz referred to this syndrome as "hospitalism," which might be better called "institutionalism." The children in this original sample

suffered both separation from family and institutional emotional neglect, although they were well cared for physically. In most cases, neither maternal care nor family life was restored to these children.

Further studies (Spitz & Wolf, 1946) of a more discrete syndrome developed by infants separated from their mothers during the second half of the first year of life also revealed a relationship between somatization and depression. Called anaclitic depression, the syndrome is characterized by weepiness and apprehension, withdrawal from the environment, retardation of development, psychomotor retardation, anorexia, weight loss, and insomnia. Symptoms developed four to six weeks following the separation from the mother, and continued until reunion, which was generally effected within three months of the original separation. These symptoms appeared to be somatic expressions of depressive affect, specifically related to the loss of the love object.

Why should depressive affect take the path of somatic expression? In infancy and early childhood, in particular, we might speculate that since the words to express grief over loss are not available, the body becomes the readiest vehicle of expression. Developmentally, it was thought by some theorists (A. Freud, 1970; Group for the Advancement of Psychiatry, 1966) that in infancy there is a sort of semipermeable membrane between psychic and somatic experience, so that there is easy access from mind to body, and from body to mind. Bodily excitations such as hunger, cold, or pain may easily be “discharged” through mental pathways in

the form of affects such as anxiety or rage. Conversely, mental distress may be "discharged" through bodily disturbances of digestion, elimination, the skin, and so on. Spitz (1951) succinctly stated the ego psychological view of somatization:

> . . . [T]he psychic system is not yet differentiated from the somatic system in the infant. What we might call psyche at this stage is so completely merged with the physical person that I would like to coin for it the term *somato-psyche.* Subsequently the psychic and somatic systems will be progressively delimited from each other. . . . [I]n the course of the first six months a psychological steering organization will be segregated from the somato-psyche. . . . This organized, structured, conscious steering organization is the nucleus of what we call the ego, a body ego in the beginning. It is thus delimited from the remaining conscious part of the somato-psyche, which we will designate as the id.
>
> (p. 256)

The idea here is that in infancy and early childhood, there is more "overflow" or permeability between mental and bodily experience. With development and maturation, experiences from each of these domains form structuralized systems which are increasingly differentiated from each other. What Spitz failed to stress is the continued linkage, especially on unconscious levels, between psyche and soma throughout life.

AN OBJECT RELATIONAL VIEW OF PSYCHOSOMATIC EXISTENCE

As Freud (1923) originally stated, the ego is first and foremost a body ego, not merely a surface but the projection of a surface. What I intend to delineate are original tendencies toward integration of mind and body, as expressed through psychosomatic existence. Dissociations of mind from bodily experience, resulting from relational experiences that mold the development of the self, predispose the inpidual to somatic symptomatology and to depressive states.

Object relational perspectives focus on the ability to tolerate depressive affect, which is seen as adaptive and developmentally appropriate. Depression is considered a basic ego state; the focus, then, is on various prototypes of the capacity or the failure to accept depressive affect and depressive states (Winnicott, 1962/1965; Zetzel, 1965). The depressive position is an achievement in emotional development (Klein, 1940/1975; Winnicott, 1954-5/1978), a movement from the ruthlessness and part-object orientation of the early relating which is characteristic of infancy, to the capacity to recognize both the self and the other as whole persons, capable of both loving and of hating. Along with this recognition of the fundamental separateness and integrity of self and other comes the beginning of empathy, of the capacity for concern. Stern (1985) similarly described this achievement as the discovery of intersubjectivity: with the recognition of the separateness of self comes the discovery that subjective states can be shared. This realization involves apprehending that others, distinct from

oneself, can hold or entertain a mental state which is similar to the one held by the self. The term Stern gives to this realization is the acquisition of a theory of separate minds. Paradoxically, the recognition of the separateness of self allows for the realization that inner subjective experience is potentially shareable with someone else. This developmental achievement, whether called the depressive position or the discovery of intersubjectivity, is thought to occur between six months of age and a year.

Why should depressive affect be associated with such a positive and remarkable achievement? Because, as the infant, who is a whole person, is able to identify with the whole person of the mother and other primary figures, the infant begins to recognize that the one loved so dearly is also the one hated in the bad or the hard-going moments. In Kleinian (1940/1975) terms:

> . . . the introjection of the whole loved object gives rise to concern and sorrow lest that object should be destroyed [by negative affects of frustration, hatred, and rage], and that these distressed feelings and fears . . . constitute the depressive position .... In short, persecution (by "bad" objects) and the characteristic defenses against it, on the one hand, and pining for the loved ("good") object, on the other, constitute the depressive position.
>
> (p. 348)

The anxieties of the depressive position are twofold: those that center on concern for the other and those that center on concern for the self. Anxieties about

the love object include concern that the object may be damaged or even destroyed during those moments of frustration and hatred. Anxieties about the self include fantasies about one's insides or inner life, and concerns that good internal objects will be lost due to one's own bad impulses. In mourning (and in Spitz's babies who suffered anaclitic depression), there is the actual loss of the loved person, which in its extreme may cause one to feel hopeless about relationships and external contacts in general; pathological mourning is an example of such a state. In the depressive position, there is the recognition that one's own anger and hatred may lose both the loved object and the internally felt goodness of the self.

Hypochondriacal symptoms can be seen as manifestations of either paranoid or depressive anxieties (Klein, 1935/1975). Somatic symptoms which in fantasy represent attacks of persecuting objects are typically paranoid. Those symptoms which are handled through projection— as the Yoruba, referred to earlier, who attributes his symptoms to witchcraft; or the Italian peasant who attributes her headaches to the evil eye—are examples. Somatic symptoms that derive from the fantasied attacks of bad internal objects on good ones, in which the inpidual is identified with the sufferings of the good objects, are typically depressive. For example, a well-behaved, phobic, eight-year-old boy who was unable to ask directly for food talked, in his therapy sessions, of a hunger monster inside him that was never satisfied. The monster would eat wood and metal and could eat up the whole room if it were let out.

The ways in which inpiduals work through their depressive position determine their capacities for full relationships and for healthy living. Healthy reparative tendencies, which serve to integrate aspects of love and aggression so that they can be experienced in relation to self and others without fearing sadism and destruction, would mitigate tendencies to somatization. The ability to tolerate depressive affect is linked to the recognition of one's own aggression, and to the capacity to "make good" for destruction wreaked on loved objects. The inability to tolerate depressive states is reflective of an internal state in which the inpidual feels not only abandoned by all good objects, but subject to attack by all bad ones. The sense of guilt that accompanies this state of affairs is often turned against the self, in the form of somatic "attacks."

SPLITTING AND DISSOCIATION

> The mind does not exist as an entity in the inpidual's scheme of things provided the inpidual psyche-soma or body scheme has come satisfactorily through the very early developmental stages; mind is then no more than a special case of the functioning of the psyche-soma.

(Winnicott, 1949/1978, p. 244)

In this passage, Winnicott was addressing the dissociations that occur when the natural integrative processes within the inpidual are disrupted by a bad (as opposed to good-enough) environment. Mind and body are not dichotomous, with the mind localized in one place and the body in another. Rather, there is a process of mutual interrelation between psychic and somatic aspects of the growing inpidual, with each informing the experience of the other. Like Freud's (1923/1961) body ego and Stern's (1985) core sense of self, Winnicott saw the body, as it is experienced by the inpidual, as forming the core of the imaginative, created self.

Early psychosomatic development, along healthy lines, entails the continuity of being. The ordinary good-enough mother, who actively adapts to the baby's needs in the beginning, and then gradually fails to adapt by continuing with her own life, provides the environment which facilitates "going-on-being." During this early phase, the infant develops a self: psychosomatic existence begins to take on a personal, inpidual pattern, which Winnicott referred to as the psyche "indwelling" in the soma (1960/1965). This indwelling, which is constituted by the integration

of motor, sensory, and functional experiences, is the basis for the construction of the self, of personal reality and personal experience. Impingements, withdrawal, and erratic relating on the part of primary caretakers constitute environmental failures to which the infant must react and adapt. These failures interfere with the integration of the self, with the infant's natural tendency to acquire a personal psychic reality and personal body scheme. In infancy, as well as in later life, symptoms such as eating and sleeping disorders, suicidal ideation, and other psychosomatic difficulties are likely to surface as reflections of early disintegrative experiences of psychosomatic existence.

In this view, psychosomatic symptoms are regarded as special instances of splitting or dissociation (Gaddini, 1978; James, 1979; Szasz, 1957; Winnicott, 1966). These failures of mind-body integration can be seen as:

1. Failures in the early mother-child relationship
2. Defenses
3. Means of forging a true identity.

Developmentally, psychosomatic splits arise from failures in the early relationship between mother (and other primary caretakers) and infant. Parental impingements, withdrawals, and failures of empathy require adaptations on the part of the infant which force precocious compliance and a consequent loss of spontaneity and self-integration. The lack of physical and psychical mutuality

between parent and child in infancy interferes with the natural integration of psyche and soma; psyche, then, is narcissistically damaged and turns, at best, to false self-constructions. In adapting a false self-compliance, the developing child builds up a set of false relationships (Winnicott, 1960/1965). These operate as if they are real, but they lead to a sense of inner disconnection and futility. One of the consequences of this inner disconnection is dissociation from bodily experience, which is then expressed psychosomatically.

When psychosomatic symptoms are taken seriously on a medical level, the search for medical relief can give purpose to life and distract attention from the inner sense of futility (James, 1979); such symptoms, then, constitute a defensive process. Hypochondriasis best fits this model of defense. A more compelling model is that proposed by Winnicott, which posited that psychosomatic symptoms serve to defend the inpidual against the dangers that arise out of integration of the personality. The somatic defense operates to protect the inpidual from the experience of depressive anxiety associated with the sense that the good object has been lost not through environmental failure, but through the inpidual's own destructiveness. In other words, somatization serves to mitigate the guilt, blame, and self-hatred that arise when depressive affect cannot be tolerated in the inpidual.

SOMATIZATION AND IDENTITY

Somatization also functions as a means of forging an identity and of regaining integration. Psychosomatic symptoms may be seen as a function of the self, rather than as the specific symbolic expression of a conflict. One of the aims of psychosomatic illness "is to draw the psyche from the mind back to the original intimate association with the soma" (Winnicott, 1949/1978, p. 254). In drawing attention to the dissociation, the symptom is an attempt by the inpidual to heal the split between mind and body, between idea and affect. The very fact that the symptoms are bodily symptoms demonstrates that the psychosomatic linkage is not altogether lost. Paradoxically, through the depersonalized experience of the somatization, the inpidual is attempting to get in touch with the possibility of psychosomatic integration and the personalized self.

In conclusion, two short clinical vignettes will be offered as illustrations. The first, reported by Szasz (1957), concerns a woman who developed somatic symptoms which took the form of hypochondriacal preoccupation with various parts of her body, including tingling in the extremities, "bubbly feelings" in the head, "shocks" through her body, and severe constipation. These symptoms developed soon after the woman suffered a miscarriage at six months, which was precipitated by a fall on the ice. Szasz viewed her symptomatology as the ego treating the body (in contrast to the self) as the lost object. This woman failed to work through the loss of her pregnancy with depression and grief; rather, she

transferred the lost object to the body and expressed her unfelt grief through somatic attacks. In this case example, the somatization was specifically linked to loss and to this woman's inability to mourn for the fantasied damage done.

The second is an autobiographical account (Cardinal, 1983) of a psychoanalytic journey from illness to health, where the illness contained, among other things, life-threatening somatic symptoms of chronic uterine bleeding. Innumerable medical consultations and medical treatment failed to stem the bleeding; psychoanalysis did. In Cardinal's experience, finding the words to say it constituted the "cure." She quoted Boileau, *L'Art Poetique:* "What one truly understands clearly articulates itself, and the words to say it come easily." Healing her splits, integrating what were formerly dissociated and disintegrative bits of her experience into a whole, real sense of her personal self, allowed Cardinal to "dwell within herself" in psychosomatic health.

SUMMARY

Both research and clinical data suggest that somatic symptomatology is a frequent correlate of depressive states. Classic psychoanalytic theory has attempted to address the mind-body dualism common in Western thought by regarding somatization as an unconscious expression, through bodily discharge, of thoughts and feelings unacceptable to the inpidual. Developmental and object relations perspectives tend to relate somatization to problems with the ability to contain depressive affect and depressive states. The ways in which inpiduals work through the depressive position, including integration of good and bad self and object experiences, determine their capacities for full relationships and for healthy living. Early psychosomatic development, along healthy lines, entails a continuity of self experience which may be disrupted by impingements, withdrawal, and erratic relating on the part of primary caretakers. Such disruptions interfere with the integration of self. In childhood, as in later life, psychosomatic difficulties are likely to surface as reflections of such early disintegrative experiences. In this view, psychosomatic symptoms are regarded as special instances of splitting or dissociation. The somatic defense serves to mitigate the guilt, blame, and self-hatred that arise when depressive* affect cannot be tolerated in the inpidual. Paradoxically, through the depersonalized experience of somatization, the inpidual is attempting to get in touch with the possibility of psychosomatic integration and the personalized self.

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