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PSYCHOSOMATIC "ARC" IN THE PSYCHO-THERAPEUTIC PRACTICE

Ivanka Boncheva
Department Psychiatry and Medical Psychology,
Medical University – Varna, Bulgaria,

ABSTRACT

The psychoneuroimmunology, the new brain science and the endocrinology today show a lot of results, with which symptoms are better to understand. The psychotherapeutic practice shows the ways to influence them by encoding the levels of bounding between the physical symptom and the psychological condition.

The aim of the study was to show the encoding of the psychosomatic arc within a real psychotherapeutic contact. 59 psychotherapeutic cases are followed. 33 of them were with somatoform disorders and 26 with chronic psychosomatic diseases. Every patient has minimum 12 psychotherapeutic sessions. The treatment is provided on the base of the 5 levels model of the positive psychotherapy.

We ascertain the following:

1. The most significant moment in the arise of such symptomatic is the gained past experience - "vital concepts"; "coping strategies";

2. Unlocking moment for the arise of the affection is the fixed emotion - fear, aggression or depression, specific for the particular morbid pictures;

3. Showing the connection between symptom and fixed emotion by the technique "positive interpretation", which unlocks the process of changing

This shows that the psychotherapeutic help is possible only if the patient rethink the psychosomatic arc. Showing the connections between the content of the unconscious, the fixed emotion in behavioral models and the symptom gives the impetus to change.

Key words: Psychosomatic arc; connection between unconscious – fixed emotion – symptoms; positive psychotherapy.

The interaction between somatic disease process and the mental activity of the individual has impact in the doctor's Hippocratic Oath. Since ancient times till nowadays there are different scientific theories that reflect the psychosomatic mutuality. The orthodox psychosomatic medicine [1] defies the morbid bodily manifestation as conversion – ejection of the drive impulse. Z. Freud and his followers [2] seek the psychological "roots" of the somatic illnesses in the ability of the person to experience and shows his/her aggressive impulse. The theory of H. Sally for the stress grounds the psychophysiological interpretation of the psychosomatic relation. On that base many deep and behavioral psychotherapeutic schools defies the building and restoring of the patients to cope with the stress as their main preventive and rehabilitation task. The scientific developments of the concept "experience" [3] bring the understanding of the disease as a whole psychological answer of the individual to biological, mental and social stressors [4]. In psychotherapeutic plan specialists started talking about coping strategies as "healthy" or "morbid" answer and the necessity to help the patient achieve a better quality of life [5]. The psychoneuroimmunology, the new brain science and the endocrinology today [6] show a lot of results, with which symptoms are better to understand.

In 1991 N. Peseschkian [7] illustrates the psychosomatic unity in the so-called PT-arc, showing the achievements of the psychoneuroimmunology, the brain science and the endocrinology about the deep connection between the work of the "body substrate" and the mental activity of the ailing. On the other hand, the psychotherapeutic practice starts seeking the path to achieve decoding of that coherence with the ailing. The aim was to find the individual reserves to cope with the illness.

AIM AND TASKS:

The aims of our research are to show the decoding of the psychosomatic arc in a real psychotherapeutic contact on the base of positive psychotherapy.

Our task is to expose on experience level the key moments of the connection between body and mentality and to follow the dynamics of the change in the ill's experiences during the spontaneous psychotherapeutic exploration of the ailing.

MATERIALS AND METHODS:

59 psychotherapeutic cases are followed. 33 of them were with somatoform disorders and 26 with chronic psychosomatic diseases. Every patient has minimum 12 psychotherapeutic sessions. The treatment is provided on the

base of the 5 levels model of the positive psychotherapy by N. Peseschkian [8]. Within PPT-interview and during the therapy there were registered the patient's experiences served as spontaneous shares.

The ill patients with somatoform disorders (33) are at average age 27; men = 15; women = 18. The ill patients with psychosomatic chronic diseases (26) are at average age 32; men = 10; women = 16.

The patients are separated in groups by the diagnosis as follows:

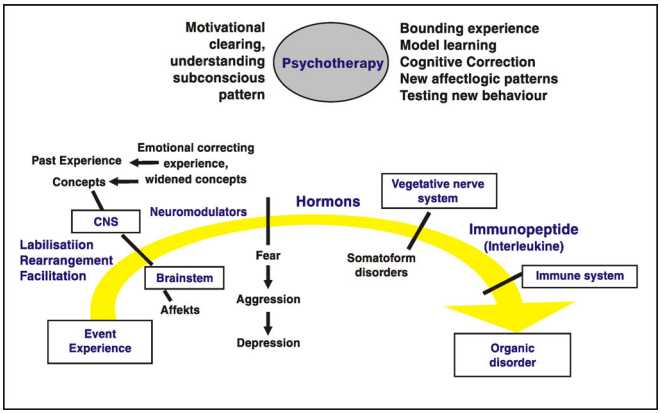
Group A/ Somatoform disorders
Phobic anxiety disorders = 5
Panic disorders = 8
Obsessive-compulsive disorder = 10
Somatoform vegetative dysfunction = 10

The willingness of the majority (63% of all) to use psychotherapeutic help emerges after at least 6 months or a year of a medical therapy. In only 34% of the others the attitude for psychological psychotherapy precedes the willingness to use medical help. Decisive factor is the unwillingness to load the body with drugs.

Group B/ Psychosomatic illnesses
Asthma = 5
Ulcerative colitis/gastritis = 6
Diabetes = 5
Hypertension = 10

All of the ailing have their diseases for at least 3 years. They had a systematic contact with a specialist doctor and were prescribed maintenance therapy. The idea for psychotherapeutic help amongst 81% of them arises because of their own willingness to cope with the social problems surrounding the illness – conflicts in family; problems at work and school; trouble contacts. Only amongst 11% of them the motivation for psychotherapy is created by heard of read information for the psychosomatic mutuality.

Fig. 1. Psychosomatic arc.



The PT-process is accomplished according to the 5 level model of N. Peseschkian and visualized by the elements of the psychosomatic arc.

RESULTS:

A) The psychosomatic "arc" during the PPT-interview

Aim of the PPT-interview is the building of the initial connection between the shared morbid symptomatic and the experience of the symptom.

I. ***Observation/distancing***

Table 1. Predominant style of experiencing the illness

No	***Illness***	***Bodily symptoms***	***Experiencing the symptomatic – leading emotion***
	Phobic anxiety disorder	anxiety; palpitation; physiological expression of the horror from the phobic object	Intense ***fear*** from death, loss of control; going insane
	Panic disorder	Anxiety attacks; palpitation, suffocation, dizziness	Intense ***fear*** for life, willingness to run away from situation, fear from loss of control and going insane
	Obsessive-compulsive disorder	Intrusive thoughts or actions, anxiety, displeasure, excruciating moral censorship;	***Depressive*** moral self-abusing because of a low self-esteem''How can I think this way? Why am I doing these meaningless actions?''
	Somatoform vegetative dysfunction	Changing bodily symptoms without any somatic medical reason	Intense ***fear*** from diseases, ***aggressively*** charged dissatisfaction with doctors "uninterested behavior"
	Asthma	Allergic attack, difficulty breathing	***Fear*** from the arise of the attack; ***anxious depression***
	Ulcerative colitis/gastritis	Impaired bowel – aches	***Depressive*** heaviness, isolation
	Diabetes	High blood sugar; feeling of dry mouth; fainting	***Anxiety; fear*** from additional complications
	Hypertension	Stronger heartbeat; noise in the ears; feeling "faint"	***Fear*** from serious damage to the heart; fear for life

The ailing in both groups show that they experience the illness as an unwanted burden (100%); **stress** (72,9%). In most of the cases the surrounding emotion is fear expressed in its milder form as anxiety to lose control over the body (69,5%) and in its most significant form as fear for life, fear of death (30,5%). Probably the closeness in the bodily symptomatic makes ***the emotions from experiencing the disease one and the same*** in both groups. Although the ailing with somatoform disorders know the explicit opinion of the doctors that the body substrate is not damaged, they live with the fearful expectation that in the next moment this will happen. They understand that this fear makes them dependant on the doctor.

The therapeutic help in this first stage starts with uncovering the specific function of the disease with the help of the technique "**Positive interpretation**". Generally it lets to see the disease as:

a) A chance to change which should start from the ailing;

b) A signal that outside, in the socium there are events creating negative feelings which the individual carry more painfully than the symptomatic;

c) A sign that time is needed for self-preservation; for gathering new strengths

The positive interpretation in the beginning of the therapeutic contact was perceived from the ailing with relief: group A - 63% of the patients; group B - 38% of the patients. The others were skeptic or defensive.

In the end of the PT-contact 76,2% from all of the patients in both groups shared that the possibility to see the function of the symptomatic differently helped them "to help aim their efforts in new direction".

II. Inventory

The second therapeutic stage gives the possibility to follow the psychological connection between the style of experience /fixed emotion/ and the contents of the three levels of mental activity - conscious, subconscious and unconscious.

Table 2. Predominant contents of the experience in the levels of mental activity

No	***Disease***	***Conscious /Concepts/***	***Subconscious /Coping-strategies/***	***Unconscious/Fixations/***
	Phobic anxiety disorders	Aims and achievements are important	Self – realization Self activity	***Aggressive feelings***
	Panic disorders	It should be successful!	Dedication in activity and contacts	***Fear*** from rejection
	Obsessive-compulsive disorders	I should be accepted by the others	I do whatever they want	***Depressive feelings*** because of hidden aggression
	Somatoform vegetative dysfunction	I do the best!	Self activity in service of ideals	***Stenic auto-aggressive feelings***
	Asthma	The others should approve of me!	Activity because of keeping a contact	***Auto-aggressive feelings*** Dissatisfaction with self
	Ulcerative colitis/gastritis	It's all up to me! Achievements!	I work and work. I don't save my strength.	***Depression*** because of hidden aggression
	Diabetes	I need to be approved by the others! Contact!	If it is necessary for the others – I do it!	***Fear*** to be disapproved
	Hypertension	I can do the best!	I do everything by myself!	***Stenic feelingsAggression***

The data from the tables show that according to the contests in the previous psychological experience the different groups of ailing create ***distinctive predisposition to fix the emotion*** from the levels of ***fear*** – to patients with panic disorders and diabetes; ***depression*** – to those with obsessive-compulsive symptomatic and ulcerative colitis/ gastritis and ***aggression*** to all the others. This psycho-vegetative information is developed by the body with the help of the neurotransmitters from the cerebrum to the vegetative nervous system. The information is revised trough hormonal to the immune system.

Rationalizing the fixed emotion in PT-contact becomes possible with the usage of "***Visualization***", ***transcultural and meaningful*** approach.

As feedback the patients share:

• "I saw the picture of my disease. Now I feel relaxed." : Group A = 30% from the patients; Group B = 26,9% from the patients

• I haven't thought that my emotional attitude could reason/contribute my disease till now." : Group A = 84,8% from the patients; Group B = 80,9% from the patients.

III. Situational encouragement

The examined patients showed that they are socially

oriented with the presence of secondary abilities. In defense of their place in the socium a part of them are willing to ignore the emotional signals of the … negative emotions. Mainly these are the patients with phobic anxiety conditions, obsessive-compulsive disorders, asthma and diabetes. The ailing with panic disorder, somatoform vegetative dysfunction, ulcerative colitis/gastritis and hypertension are fixed … emotionally more over the experiencing their own value, i.e. over the selfish beginning. In both groups the ailing can't use negative emotions as regulator between social and selfish unity of the personality.

IV. Verbalization

The development of the emotional contests "What I want – What I show outside" lets the formulation of the psychotherapeutic task. It defies the contest of the collaboration till the end of the contact. At this psychotherapeutic stage the patients share the following dynamics of change:

• «The fear of the attacks has gone now» : group A = 90,9% from the patients; group B = 88,4% from the patients

• «The crisis has accompanied me less» : group A = 72,7% from the patients; group B = 57,7%

• «I know where I should aim the efforts for change – not outside and not for coping with the disease, but to rearrange myself» : group A = 84,4%; group B = 65,4%

V. Extension of the objectives

According to the shared changes after the third, seventh and twelfth meetings the patients reduce most of all the fear from the symptomatic. Secondarily, they show willingness to hold under control the suitability of the used coping-strategies. In greater, to the neurotic patients (72,2%) and, in lesser degree, to those with psychosomatic diseases (42,3%) the frequency of the manifested fixed emotion is reduced.

DISCUSSION:

The path of decoding the psychosomatic "arc" in therapeutic contact goes trough: 1. Detection of the emotion that accompanies the disease; 2. Following the life experience of the individual which has allowed him/her to form a specific style of emotional reacting /fixing the emotion/; 3. Differentiating the **emotional attitude to the disease** and the **fixed emotion**; 4. Showing the mechanism of contribution of the fixed emotion in the arise, passing and maintenance of the morbid symptomatic; 5. Discussion and testing the ways to degrade the emotional fixation.

All of this allows the mobilization of the patient's mental powers to cope with the disease. As a felicitous help for self help in the therapeutic process the patients reported the usage of the following psychotherapeutic techniques: visualization with the help of the psychosomatic arc, positive interpretation, visualization of the disease, transcultural approach.

The received results motivate the necessity of examining the psychological reason which in a kin dynamic leads to a psychosomatic disease or allows the person to have only somatoform disorders.

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Address for correspondence:

Assos. Prof. Ivanka Boncheva, PhD.

Department of Psychiatry and Medical Psychology,

Medical University – Varna, Bulgaria,

1, Hr. Smirnenski Boul., 9010 Varna, Bulgaria,

Mobile: +359887 722 581

E-mail: ibontcheva@yahoo.com;