Introduction

Towards a Theory of Psychosomatic Disorders

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Psychosomatic medicine had its origin in psychoanalysis at the beginning of this century and has only struck out on its own in the last few decades. Psychoanalysts were the first to trace causal and theoretical connections between mental conflicts or situational stresses and physical symptoms. Today it is still the subjective dimension – a person's experience of his own inner life history – as reflected in the psychoanalytical situation and in the course of psychotherapy, which is the corner stone of clinical research.

The first attempts to define psychosomatic disorders were variants of concepts stemming from neurosis theory; the physical symptom was seen as a special case of neurotic conversion and was attributed to the psyche. However, the question of whether psychosomatic medicine can 'emancipate' itself from psychoanalysis has been in existence for a long time: must it not give its research into aetiology, its concepts and theories and its methods of treatment more well-defined contours, if it is to exist as a separate entity?

One thing seems to us to be an established fact in psychosomatics as opposed to neurosis psychology: a psychosomatic medicine conscious of its own individuality sees its circumstances and its existential justification to a much lesser degree purely in the conditions of psychogenesis. This can be seen most clearly in the field of somato-psychosomatic problems. Here, the question arises of how primary physical disorders are psychologically assimilated and their subsequent course influenced by this psychological reaction. The experience of physical sickness is open to multi-factorial interpretation with regard to its origin, and invites a number of independent somatic and psychological theoretical approaches. Today we attempt to understand physical sickness in the interaction of somatic and psychic influences.

From a historical point of view, a differentiation can perhaps be made between two different developmental tendencies in psychosomatic medicine

which exist in a fruitful opposition to each other and which have proved to be relevant questions in research. The one direction tends more towards specifying a disease, locating an internal or external conflict, or a trait of personality – the other seeks to determine the common denominator of various psychosomatic diseases and to comprehend and work on this aspect. This last approach, which is the more recent, was magnificently formulated in the work of *Jürgen Ruesch,* to which far too little attention has been paid. Shortly after the second world war, *Ruesch* very accurately described the affective disorder in communication and the restricted fantasy life, the object dependency and the overadapted social behaviour of the 'infantile personality' as the 'core problem' of psychosomatic patients.

Thus, it is against this background, but in a new terminological guise – pensée opératoire, alexithymia, psychosomatic phenomenon – that the 11th European Conference presents an old problem as its main theme: the specific hypothesis of whether and to what extent psychosomatic patients can be differentiated from psychoneurotic ones.

We are thoroughly convinced that the hypothesis of alexithymia is not only an interesting, hotly disputed, clinical observation. We hope, rather, that the particular point of view it represents will act as a kind of 'paradigm' to support the discussion and substantiation of the present psychosomatic theories and research approaches. It seems to us that the alexithymia hypothesis is open to the question whether the course of the disease should be viewed more from the aspect of the psychosocial situation of being ill – that is in respect of certain separation and loss reactions – or from the aspect of personality features which can be objectified in psychological tests. It also seems to beg the question of whether and to what extent the disease is determined by a predisposing factor to be sought in the organic systems, or whether a proneness to certain types of reactions should be looked for. Other elements which must be considered are linguistic hypotheses and family dynamics, which point to a connection between individual, family and social factors.

Scientific progress in our branch of medicine must always return to the central experience of observation of the patient. Advances are made in stages, in which the duality of experience and observation coalesces to create certain key concepts and hypotheses. We expect today, more than in earlier times, that hypotheses be presented in a systematic, comprehensible fashion which makes them capable of being repeated and tested critically by others. Every researcher must permit himself and others the possibility of confirming a statement or of correcting it. The ever-present question is: what forms of investigation are

most appropriate to the various statements and theories; introspective or observational, accompanying treatment, or purely experimental, retrospective with regard to the patient's biography, or prospective, anticipating the future?

One aspect requiring further attention is the relationship between research and therapy, a particularly crucial point. It is true to say that from the very beginning, therapy has not been merely a testing-ground for hypotheses; the therapeutic situation has rather – particularly in psychosomatic medicine, been a constant source of observation and new theories in its own right. For this reason we thought it fitting at the 11th European Conference on Psychosomatic Research to treat the concept of alexithymia from three viewpoints: (1) observation; (2) aetiology and evolution of theory and (3) therapy.

This volume does not only contain contributions by the prominent champions of the alexithymia theory. The large number of papers devoted to clinical observation and to objectification are of particular value. Remarkable statements are also made by authors who are sceptical of the alexithymia hypothesis, and will remain so. We are very much in need of their criticism and their intimations if we are to make our observations, our theoretical approach and our research methods as good as they could be. We hope that the reprinting of part of the discussion will give the reader an impression of the frankness with which it was conducted and also give him the opportunity to check his own standpoint by means of a 'dialogue' with the authors.

In the description of the alexithimic psychosomatic patient with his emotional defence system and his concretistic way of thinking, a human being is being classified as a type. Here as so often, typological description seems not far removed from caricature, the psychosomatic patient becomes a strange species of humanity who seemingly does not exist among us. However, as therapists, we should never dissociate ourselves too completely from the patient, and should never forget when speaking of the peculiarities of our patients that we are all just as susceptible to psychosomatic illness as they are. There is scarcely anyone among us who will never encounter a situation where his psychological assimilation faculties are no longer able to cope and he reacts psychosomatically. Even if it is tempting – at least at the present stage of our knowledge – to see the psychosomatic patient as a 'type', we should still attempt to progress towards regarding the psychosomatic reaction as a situation where the psychological defence mechanism is overtaxed and where any one of us might fall back on physical reaction.