

Embodied Experience: The Psychoanalyst and Medical Illness

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I think the film which most quintessentially captures cross-cultural bewilderment is *Lost in Translation*. In a commercial shoot early in the film, the protagonist, Bob Harris, played by Bill Murray is pressured to perform the *savoir-faire* associated with his film persona while advertising an alcoholic product. The director shouts at him for ten minutes in staccato Japanese which is translated by a solicitous female interpreter, as “More intensity, please.” “Didn’t he say more than that?” Harris asks. The director releases another vehement barrage of instructions. “Yes?” Harris asks. “More intensity, please.” Harris, aka Bill Murray, grimaces and mimics whatever “intensity” might signify in this context, and clearly longs for the alcohol.

I find my work with medical illness often gets lost in translation. Mismatched assumptions snag my conversations with physicians about patients I’m treating, and sometimes disrupt interaction with the very same patients in my psychotherapeutic work.

However, I think there’s an opportunity embedded in the struggles of translating across disciplines and areas of scholarship. Psychoanalysis has moved forward through an examination of its jagged edges, rarely its polished contours. Harry Stack Sullivan in the 1950’s joined a biologically derived psychoanalytic theory to the burgeoning social sciences and expanded our developmental and diagnostic perspective. Feminist theorists have challenged fundamental concepts regarding character development and gendered dichotomies. In truth, if we want to honor the legacy of Sigmund Freud, it is by looking at psychoanalysis as a “project” worthy of open investigation and interdisciplinary challenge.

What I experience in working with physicians is a collision of two different paradigms as well as two different language systems. I am often referred patients whom physicians can’t help, with the assumption that there is a specific etiological agent I can identify whose eradication will produce

symptomatic relief. Sometimes patients are referred when they complain about work pressure, or distressing relationships, but these complaints are often read by physicians as pathonomic indicators, like a deficient white count. The rub is that people who are ill, though they often complain about their doctors and medical care, are likely to be more identified with the medical model than with ours. Patients want results, and our commitment is to process. Additionally, we live in a culture of commodities and products, and the body is one of them—a product to be recycled or updated. Our culture sanctions the belief that bodily constraints can and should be erased or reversed.

Within the context of this belief system, when doctors and patients are interested in a psychotherapeutic referral, they rarely privilege the investigation of unconscious processes and the therapeutic co-participation that we offer. Our step-siblings, the cognitive behavioral therapists, are embraced readily, offering easy solutions to “stress management” and efficient problem resolution.

A word about medical practice: The problem of translation occurs when we psychoanalysts talk with physicians; our discursive and exploratory approach often bewilders physicians. It is useful for us to reflect on the perspective of the physician, however overly data driven and positivistic we can find her epistemology. For example, in an incisive critique of our epistemological insularity, Westen (2002) asks, “And how many of us would be content to have our child treated by a physician who says that he ‘resonates’ with particular theories of leukemia and that, although he has not read much of the empirical literature on it since school, he believes cells can be understood from a multiplicity of angles, none of which constitutes the whole truth?” (p. 888).

To some degree, we psychoanalysts have been our worst enemy in the health care area. In my long-term work with patients suffering from ulcerative colitis and Crohn’s disease (Gerson, 2002), including consulting with a foundation and a major medical center, I had to bridge the chasm between my discipline’s premature conviction that ulcerative colitis was a psychogenically organized syndrome and the contradictory, certainly non-confirmatory empirical data. Treatment studies have not supported psychological correlates, nor the usefulness of psychotherapy towards symptom reduction. Yet it is rare that I mention this illness to a psychoanalyst without encountering conviction that its

place among the original big seven of psychosomatic illnesses remains unchallenged (Alexander, 1950).

Our own jump to explanation is likely countertransferential in origin. Psychosomatic illness—the sudden emergence of symptomatology without physiological explanation and without therapeutic relief—is threatening and we feel pressed to provide an explanatory schema to relieve our own anxiety. I think we often jump to explanation rather than staying with personal meaning. We try to protect our sense of potency by staying within our own language system, rephrasing rather than attempting to bridge or translate. It's hard not to because the existential inequity of illness—that is, who is well and who is not—is disturbing to all of us. It is a random and cruel role of the die. Other forms of distress that patients bring to my office seem more plastic, more potentially rendered in symbolic form than physical illness. What's more, the randomness is alarming in another way: my own physical vulnerability lurks at the margin of my conversation with a sick patient. I could easily be the next person asking, "Why me?"

Within the psyche-soma area, I've shifted my intestinal focus to Irritable Bowel Syndrome, and to a collaborative project with my husband, a gastroenterologist. IBS affects approximately 10% to 15% of the population and can severely compromise quality of life (Thompson, et al, 1994). As one patient put it, "I can barely remember life without embarrassment and without pain." There is a significant incidence of psychological distress in IBS patients, as well as the suggestion in one well-designed study, that anxiety and depression facilitate the development of symptoms (Bennett, Tennant, Piesse, Badcock, & Kellow, 1998). Several investigators have explored the effect of childhood sexual and physical abuse on IBS ; in some studies the incidence of childhood abuse significantly differentiates IBS patients from those with organic gastrointestinal disease, and in others results are inconclusive (Drossman, Talley, Leserman, Olden, & Barreiro, 1995). IBS affects three times as many women as men, evoking a range of explanations, including hormonal effects, and gender patterns in health care seeking, Though not originally identified as "psychosomatic," IBS has proven quite responsive to various psychotherapeutic interventions including short term-

psychodynamically oriented therapy, cognitive behavioral therapy and hypnotherapy, as long as symptomatology and coping remain a major foci of the treatment (Blanchard, 2001).

Once patients suffer from chronic IBS symptoms, they are unlikely to feel relief without psychological intervention (Blanchard, 2001). Psychotherapy is most relevant in processing the meaning of symptomatology. When the experience of illness is located in experience, it seems to lead to a greater sense of mastery of symptoms and, very possibly, to a reduced gut hypersensitivity or increased pain tolerance. But this remains conjecture; when we jump to causal explanation for symptomatology—the lightning rod of physicians—we in fact sequester ourselves within the medical language system, not our own.

Nevertheless, gastroenterologists don't readily refer to mental health professionals. Most patients who seek specialist care continue to have symptoms, and they inevitably choose to see yet another specialist, who performs the same cluster of expensive tests, draining health care dollars—\$1.6 billion in direct and \$19.2 billion in indirect costs (Sandler et al., 2002), and more importantly, rendering the patient even more hopeless and symptom preoccupied.

In a carefully designed clinical research project, my husband and I saw 19 patients together for three biweekly interviews. We focused on the circularity of psychological distress and physiological discomfort; asked about memories of first occurrence of illness and correspondence in current life; inquired how illness was constructed across three generations of family life, and how significant others currently responded to and participated in the experience of illness. Our results were impressive: a highly significant decrease in symptoms after only three conversations, maintained at three month's time. Our ongoing need to translate between our epistemologies necessitated openness to new possibilities, and thus we located hypotheses we weren't looking for. For example, people with IBS have been characterized as learning to somatize from their parents (I often find this statement pejorative). Our conversations made us aware of something unreported about the childhood experience of patients. Many of the individuals we worked with had lived with parents who had seemingly denied or mismanaged serious illness, flooding the patient with constant and disregulated anxiety in childhood and adolescence. A subsequent international study we conducted has indicated

that across countries as diverse as India, China and Mexico, reported relationships with significant others has a major impact on the intensity of the illness experience (Gerson, M.J. and Gerson, C.G., 2006)—that is, across these cultures conflict in intimate relating was predictive of worsened symptomatology. Once again, we were surprised by the commonality of this finding across such different cultures, but we conjecture at this point that since the data was collected in urban settings, that urban cultures share a global perspective on mind-body interactions that urban-rural subcultures may not. Here the question of translation is relevant to the medical, the psychological and the anthropological!

I've had ample opportunity to become fluent in another language—medicalese—However, I can still feel disequibrated. I feel derailed for three reasons: Firstly, there is the issue of translation to a medical language and epistemology. Secondly, patients, often want to work instrumentally with me, to relieve pain or discomfort, with enhanced self-understanding often regarded as a luxury item in our collaboration. And thirdly, when the patient becomes engaged and the symptoms remit, I still have to maintain a high degree of tolerance for uncertainty, since the means of explaining why the symptoms remit remains elusive.

I'd like to offer three clinical examples illustrating my work with IBS diagnosed. I'm going to transgress a clinical tradition and begin with what we might consider a "failed" treatment. After all, if my purpose is to expose disjunctions, it would not be appropriate to begin with coherence and comfort, but rather to end there.

A clinical example: Jim told his physician he wanted symptom relief from IBS but had no psychological issues to address. "Are you sure?" his doctor asked. "Yes, work is tough but gratifying, family is great. I mean I haven't talked to my father for over a year, but I don't think that bothers me." The referral is made. My work with Jim was an exercise in dual-coded language systems, if not cultures. Jim wanted symptom relief. I was astounded by the number of psychological issues facing him.

Jim and I shared a common language when we were talking about pain, the unpredictability and mystery of symptom appearance. I felt empathic in these exchanges. This is what I do: I listen to and recognize subjective renderings of experience.

The disrupted translation occurred when I inevitably introduced the heart of my clinical belief system: Jim offered me a psychoanalytic banquet of dynamics, the break in relationship with his father as a mere appetizer. What emerged from my inquiry into his life and experience? His father felt second rung to Jim's wife's family, which had become more primary. His father expressed dissatisfaction; Jim's wife said she'd never forgive him, and that was the end of the father-son relationship. But it was only the beginning of the story. Jim, besides a taxing work life, was essentially responsible for most of the crucial home management chores. He couldn't criticize his wife because, "She is so good, and, unfortunately, very sensitive to criticism." He found his kids unmanageable; they were noisy and rebellious and he often felt sicker on the week-ends. And he worried about his daughter; she was shy and often said she couldn't participate in an activity because her stomach ached.

His IBS had first occurred in the midst of his kitchen renovation, which was utterly disruptive of eating patterns. In something like the sixth meeting, we talked about his mother; his early life had been utterly chaotic. After his parents divorced in early adolescence, his mother periodically gave him sumptuous gifts and then, when her funds emptied, the phone was shut off and their car was repossessed. He felt guilty about his relative inattention to her in her last decade and didn't like to think about her sudden death six years ago, which he thought was possibly a possible suicide.

A few sessions later, we returned to his mother. "We often had to cancel plans because my mother was sick, generally throwing up. I think she may have done it to herself. She always had something wrong with her; in fact she insisted she had an ulcer when doctors denied it. She managed to have two operations which weren't necessary. I think they'd call her Munchhausen today, heard that term. She went into a deep depression when my younger sister was born; my sister wasn't wanted and her life shows it."

This material is beyond drenched with meaning from our perspective. But Jim was not interested in exploring meaning; he wanted respite from discomfort. For him "no pain, no gain" is a cruel aphorism. Though I tried to bridge our language barriers by reminding him of the findings that psyche is linked to soma for this syndrome, he was correct in insisting that the data does not predict individual improvement, nor is it conclusive. During the first half of our sessions—and there were only

about 12 in all, spanning three or four months because of his work travel—Jim began with a health update, and half the time it was a moderately negative report. Once he came in looking brighter. “I feel better... I think that the ginger tea and peppermint oil I read about on the web are working.” Most attempts I made to engage him in psychological discussion seemed to stall, though he suffered my explorations with some equanimity. “I think what you’re describing about your mother has cast a shadow on your life,” I say at the end of a session, in an attempt to link current anxiety about disorder to the chaos of his childhood. He began the next session by saying, “I’ve been thinking about the past, but what’s the difference? It’s self-indulgent; I say, get over it.”

When he unfurled his mother’s medical history, I asked him what he was feeling. “Anger, it’s hard to think about. I’m like this with my wife, too critical.” Because I believe that the body is social and that the beliefs of significant others shape the patient’s experience of pain and disability, I pursue how partners respond to illness and whether they help provide soothing and containment. However, Jim had erected a radar screen around his marriage; alarms rang if I approached his wife’s participation in his illness. I raised this with him, my discomfit in feeling that I was being singularly questioning of her empathy towards him. He replied, “I hate not taking responsibility for myself, I hate people who make things other people’s fault.”

I can’t really say that Jim and I were utterly in different orbits. He began to think about himself a bit, for example, how much he disliked people who let him down, don’t follow through. In one session, he speculated—briefly—on an irrational need to make his wife happy at any cost. Our last session preceded my August break and his departure for vacation. He reported a worsened health condition until just the preceding weekend, which turned out to be a very good one. But he had developed a new array of symptoms: a loss of taste in the center of his tongue, aches and pains in other parts of his body. “What is this? Are they real?” he wonders. “My mother continually complained of aches and pains.”

It seems clear to me that Jim is unable to undertake any translation of bodily experience into psychological meaning or metaphor. “Perhaps your body is particularly creative; it won’t rest until you resolve some of the confusion and chaos you’ve experienced,” I say. “You know I actually miss my

mother,” he responded. “ We looked at film footage recently and there were happy times when I was really young.” At the end of the session, Jim said he couldn’t schedule a future appointment because of work complications. I never heard from him again.

Edgar Levenson often quotes a Sufi proverb that “No problem is too difficult for a theoretician.” I can retell this experience in many ways, all of them heuristic. Jim’s selective inattention to his experience, his constricted reflective functioning, my insufficient Winnicottian holding. Attachment theory offers many leads, particularly in its integrative reach towards cognitive neuroscience. Jim, likely a fearful avoidant individual, was plagued with ambivalence about receiving help, while unconsciously fearful of being neglected and abandoned. In fact, was his illness and his symptoms an unmodulated form of attachment?

However, I think at this point, I’d like to tolerate asking more questions than providing interpretive answers. I’d like to, in Harlene Andersen’s words, “flirt with my hypotheses, not marry them.” I want to be honest enough not to fault Jim for my own personal limitations, or perhaps the limitations of my discipline in explaining our disconnection. Jim had the material and I had the expertise and we didn’t connect. He lived in another meaning system, another epistemology. He wanted to be physically healthy.

I worked with another patient who was similarly inclined, interested only in symptom relief. Janet had a warm, Italian good nature, which helped her become at least superficially engaged in treatment. A woman in her early 60’s, Janet had suffered from IBS for a decade, and was currently able to pursue very limited social contacts; she had tried anti-depressant medication to little avail, and almost every holistic approach imaginable including hypnotherapy and yoga, visualization, and nutritional counseling. She had seen a therapist several years ago with limited yield. Janet was not inclined to reflect on her experience, and even less so, her relationship with me. However, she was psychologically gifted in her ability to capture the immediacy of her experience; she was snapshot taker. In a many ways, my work with her followed the structure of a traditional Sullivan inquiry: Her early life in a large sibling set was focused on a mother who was catastrophic in her world view. As we roamed across her childhood, it occurred to her that not only was her illness a way of identifying with

her mother's orange alert world view, but that she had denied her identification with her father's sense of humor and irony. What came bubbling to the surface of her consciousness were the ways she had dared catastrophe, broken the set of gloom and doom throughout her life.

But the ore line of the inquiry was Janet's present reality, a drama which reflected her long-standing characterological struggles. Janet's IBS had begun when her husband had retired. They had worked together before and she knew he was compulsive and exacting. "I visit my daughter for the weekend, and come back to find some furniture rearranged; he comes into the room and turns off the TV program I'm watching" she said. In time we were able to look at these events as expectedly irritating but personally deeply unnerving, because of the boundary violation that Janet had always felt subject to—from her mother's depleting anxiety, not to mention her grown children's emotional demands on her, including dealing with a anorexic daughter largely in remission.

At one point I asked whether her illness were not a boundary maker, that is, her own private experience which provided a "hands-off" barrier to invasion and entitlement. The notion seemed both preposterous and interesting to her. I want to mention that an off-shoot of our work was that at this point Janet saw a nutritionist—probably for the second or third time—but this time culled a dietary approach which was extremely helpful. I find that a key benefit of successful psychotherapeutic treatment of medically ill people is the optimism which leads to a renewed commitment to adjunctive therapeutics. Janet had been sick for 10 years and after working with me for four months, she felt better. Her physician corroborated the remission which the last I've heard has held for two year's running.

Janet's psychological evolution was somewhat surprising to me, as much as Jim's inaccessibility. Her illness was long, and her personal struggles longer. I would explain her improvement as largely following the metaphoric capturing of her experience of boundary-invasion which had plagued Janet throughout her life. As Bucci (2001) notes, "One cannot directly verbalize the subsymbolic components of the affective core.... To describe a feeling in verbal form one describes an image or tells a story that incorporates the contents of the schema, the events and objects and actions that may be known and shared with other people and that evoke the sensory experience and actions of the

affective core” (p. 51). In other words, together we captured what had remained unformulated to her. Janet’s basically positive transference to me allowed her to associatively tell her story of illness, linking procedural (non-verbalized) and episodic (event) memory components. However, I can’t escape puzzling over this treatment. Why did the metaphoric recasting with Janet provide so profound a link between body and mind, when it failed to do so with others? This question remains a central one in any effort to think psychoanalytically about medical illness, I believe.

Another possibility occurs to me, partly related to Janet’s somewhat revived and successful interest in seeking other professional consultation, the nutritionist. I think that when I am relaxed enough to work with patients with a sense of perplexity, even bewilderment, I can help activate mastery, including mastery over pain. It is the patient’s recognition that she is bewildering me, in Pollack and Slavin’s (1998) terms, “the extraordinary discovery of the personal vulnerability of the analyst to the patient’s impact” (p. 870) that enables the patient to claim agency in life. Paradoxically some patients look for absolute, invulnerable expertise, and yet are reassured by its absence, external to their own resources. In a sense, as Krueger (2002) notes, every symptom is an expression of hope for restitution, rather than a signifier of psychological foreclosure.

Let me conclude with a sketch of a treatment which makes me feel very comfortable. I worked on a twice-a-week basis with a young woman, Ellen, who suffered from IBS for seven years. She had been in somewhat intensive treatment previously because of a depression following the sudden disruption of a romantic relationship and entered treatment with me saying that she would have to return to talking about the severe sexual abuse of her childhood when she was ready, providing me only with the setting and perpetrators. Ellen talked rather freely about her parents, her anxieties, and her dreams.

Ellen, like Janet, took the renewed optimism of our work into her own hands and returned to a meditation and exercise program she had found useful in the past. We referred to the terror of her past abuse experience in our work as the lodestone of her anxiety, hyperarousal, and sense of betrayal by others. When her symptoms radically improved in the first month of treatment, it seemed to be a manifestation of our deepened therapeutic engagement. When her pain returned once or twice, I felt

confident that we would unpack the meaning of the outbreak, however long it took to physiologically subside. She left treatment after approximately one year with practically no symptomatology. In this treatment, I felt very comfortable and culturally (psychoanalytically) embedded. However, my point in this paper has been to highlight the mystifying and disequilibrating aspects of treating medically ill individuals, along with—in this case—the resonant and affirming work that we can do.

I'd like to close by emphasizing the counter-transference potholes that I both fall into and try to minimize in my work with medically ill patients. Most generally, I try to navigate the cross-cultural gaps in language and belief systems that this work entails, without feeling I'm totally off course. I try to tolerate the unfairness of illness, and resist ungainly explanation and interpretation. It's always an effort to remain centered in the exploratory and inquiring mode, when patients are complaining about unremitting pain and believe that I can be the source of relief. Second, I try to tolerate uncertainty, to both "know" in terms of making hypothetical connections between aspects of experience, and "not know" what really may make a difference.

The yield from these efforts, I think, is that the patient feels less like a passive victim. Moreover, new and surprising connections can emerge, like the finding in our research that pan-anxiety about illness in childhood was a spur to current pain catastrophizing. Finding a language of the body has been an ongoing preoccupation of psychoanalytic theorizing, from the beginning. Our struggle is to find, as they say, a "living language" which can open up new conversations and take us courageously into new areas of complexity.

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