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BRIEF REPORT

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Psychosomatics and  
Psychoanalytic Theory  
*The Psychology of Ulcerative Colitis and  
Crohn's Disease*

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Psychoanalytic psychosomatic theory is reviewed here with particular reference to inflammatory bowel disease, that is, ulcerative colitis and Crohn's disease. The importance of recognizing empirical research findings in conjunction with clinical inference is stressed, as well as the usefulness of exploring the full relationship context of illness.

From the beginning, psychoanalysts have grappled with the phenomenon of psychosomatic illness. Freud's (1923/1961) early statement that "the ego is first and foremost a bodily ego" (p. 26) has been expanded and instantiated in numerous clinical and theoretical illustrations of mind and body interactions. Ulcerative colitis, involving inflammation of the lining of the large intestine, is a psychoanalytic exemplar, one of a paradigmatic group of disorders, including peptic ulcer, hypertension, asthma, rheumatoid arthritis, eczema, and anorexia nervosa (Alexander, 1950). A syndrome medically very similar to ulcerative colitis, Crohn's disease, was identified 40 years later. Their symptomatic pictures are very similar,

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involving episodic and unpredictable flare-ups with fever, muscle ache, anemia, pain, rectal bleeding, and persistent diarrhea. Gastroenterologists group both conditions under the rubric of inflammatory bowel disease (IBD), favoring an etiological hypothesis that IBD is the result of an underlying immunological disorder.

American psychoanalysts have been intrigued by ulcerative colitis for five decades. Over time, the working psychoanalytic premise regarding ulcerative colitis symptomatology is the following: Individuals with characterological difficulty in expressing rage, when threatened by separation from an important object, implode the rage inward and thereby inflame and damage their intestinal lining.

There were implicit difficulties with this dynamic formulation, including a somewhat precipitous jump from description to prediction. One great risk of presenting what is hypothetical as conclusive is that certain premises become privileged. Psychoanalysts tend to assume a psychogenic etiology for this really rather mysterious illness. What begins in mystery ends in mythology.

What is the current empirical evidence for a link between psyche and soma in IBD? Minimal, yes; robust, no; inconsistent, certainly (Drossman, 1999). After several decades in which inconsistent findings were reported in the literature, a meta-analysis of 138 studies involving patients with ulcerative colitis indicated that psychiatric diagnosis was insignificantly correlated with disease status or severity (North, Clouse, Spitznagel, & Alpers, 1990). On the other hand, moderately significant correlations between depression and Crohn's disease—not ulcerative colitis—have been reported but have not as yet been subjected to meta-analysis (Helzer, Chammas, Norland, Stillings, & Alpers, 1984). Two prospective studies found no relationship between stressful life events and symptom exacerbation (North, Alpers, Helzer, Spitznagel, & Clouse, 1991; Campbell, Shannon, & Collins, 1986).

This investigation is clearly still open. There was one study reported by Levenstein et al. (1994) in which subclinical physical findings were related to life event stress. Greene, Blanchard, and Wan (1994) discovered a correlation between daily stress and symptomatology as well as an overall monthly effect, namely that high psychological stress resulted in a *drop* in symptoms 1 month later and vice versa. This is a psychological link, but one that is counterintuitive—oscillating and nonlinear.

The constraints of empirical validation notwithstanding, available data challenge linear hypotheses regarding etiology and symptom flare-

ups. Chessick (1995), in an interesting overview article of the psychoanalytic treatment of ulcerative colitis, notes that

often in the literature there is little distinction between the personality characteristics appearing as a response to having a serious life-threatening and rather humiliating disease, and those that are possibly involved in either the etiology of the disease or in producing exacerbations of it. (p. 247)

Most important, even though the empirical literature at present offers but minimal support for psychogenic exacerbation of symptomatology, patients with ulcerative colitis *frequently believe* that their psychic states determine their symptom course. What is most useful is to empathize with the patient's belief about causality without identifying with it as an externally validated phenomenon.

The particular phenomenology of psychosomatic illness matters a great deal. Rolland (1994) has developed a typology of illness along four dimensions: onset (acute or gradual); course (progressive, constant, or relapsing/episodic); outcome (fatal shortened life span, or nonfatal); and incapacitation (present or absent). IBD presents a particular challenge to relationship systems: the tolerance of ambiguity and uncertainty. Boss, Carron, and Horbal (1988) identify the ability to deal with ambiguity as the essential ingredient of successful illness coping. Imagine the challenge for an IBD patient. It is a disease of remarkable unpredictability. Symptom flare-ups strike the patient without warning, akin to Sullivan's (1953) definition of anxiety, as a veritable "blow to the head" (p. 160). Psychic gymnastic agility is required in tolerating uncertainty but remaining focused and organized enough to manage one's medication, lifestyle, and relationships.

Too often patients are burdened with the pejorative projections of physicians who are frustrated in their best efforts to relieve their suffering. I think that individuals with ulcerative colitis and Crohn's disease often become hypersomatic through desperation about symptom abatement. In truth the very term *psychosomatic* is problematic, connoting a somewhat pejorative perspective toward disease tolerance and management (Drossman, 1992).

Our own jump to explanation may be countertransferential in origin. There is something so chaotic and threatening about what we have deemed psychosomatic illness—the sudden emergence of symptomatology without physiological explanation and without therapeutic relief—that we often feel pressed to provide an explanatory schema to relieve our own anxiety. The existential inequity of illness, that is who is well and who is

not, is disturbing to all of us. Harry Stack Sullivan (1940) wisely opined that “everyone is more simply human than unique, and that no matter what ails the patient, he is *mostly* a person like the psychiatrist” (p. 96). However, illness is unique, unshared, and unfair.

### The Relationship Context

There is a very strong undertow in working with the chronically ill to split and personify oneself as the good object and the significant others in the patient’s life as derelict and uncaring. In this vein, the clinician’s response to chronic illness is enriched and strengthened by an awareness of the relationship context of illness. Illness is coconstructed between the “sick” patient and significant others, who come to share a culture of illness beliefs and expectations, and attention to these shared and often unconsciously shared and transmitted premises is often helpful. If in fact one of our working hypotheses is that psychological distress and conflict move directly to soma, bypassing symbolization, then it is quite possible that interpersonal stress and negative affect will follow the same rapid-fire transmission.

Every illness presents a particular relationship challenge to significant others. The frequent onset of ulcerative colitis in late adolescence and early adulthood interrupts the essential late adolescent individuation process. Instead of time moving forward, instead of launching, the IBD patient—and his or her mother, father, siblings, and spouse—are thrown back into a developmental twilight zone of early childhood dependency, involving food and bowel surveillance, and physical care. I have often wondered whether the seemingly regressive appearance of some late adolescent ulcerative colitis patients was in large measure a byproduct of this particular syndrome’s vicissitudes.

Several researchers (Gonzalez, Steinglass, & Reiss, 1989; Wood et al., 1987) who have studied illness dynamics have noted a particular dysfunctional pattern of relationship rigidity. The family of an ulcerative colitis patient behaves as if varying its beliefs or procedures would jeopardize a tenuous structure. One family researcher found families with an ulcerative colitis patient to be particularly rigid (Sojit, 1969). We are left with the same circular riddle: Does this syndrome evoke certain relationship patterns? Or does a particular psychological culture activate it? Are both true?

Uncertainty, I have noted, leads to pejorative attributions from physicians and countertransference reactions from therapists. From family

members, it leads to blaming. Early on in my own study of IBD dynamics (Gerson, 1993, 1998), I found it necessary to introduce a code for blaming. There was often more than one target of blame within a family: the patient as poor eater or expert worrier, another troublesome family member, the patient blaming himself or herself.

In that study (Gerson, 1993, 1998)—an intensive investigation of 17 subjects and their families, spouses, or both—a tripartite typology of coping and family dynamics emerged. The typology emerged from a long, open-ended interview conducted with patients and their significant others.

One group of patients was characterized by a high degree of overinvolvement between the patient and his or her mother, often resulting in exclusion of other family members. Interactions were highly emotionally charged, but conflict was unsuccessfully resolved. The patient and mother oscillated between overinvolvement and rupture. One mother referred to her daughter going to “sleep-away school” when she left for college.

A second group fit the enmeshed and rigid portrait of the ulcerative colitis family. Emotional expression was avoided and a very high premium was placed on consensus, particularly around illness beliefs, which were solely weighted on physical as opposed to psychological manifestations. One father commented proudly, “We all have ulcerative colitis.”

Group 3 was the most interesting in that it did not conform to previous descriptions of so-called psychosomatic functioning. Patients and family members were active information seekers but tolerated the ambiguity of IBD knowledge. Above all, the patient was granted adequate space to withdraw or engage. In one family, a sibling felt free enough to talk about his envy of the attention granted his brother because of illness, even though that response made him feel guilty.

Across groups, we found that patients and significant others differed in terms of whether they perceived of IBD as a threat or an opportunity for mastery. When it was viewed as a threat, illness appeared to be a metaphor for all the disappointments and losses that had occurred in the family’s history and encompassed the feeling of helplessness and lack of control that generally characterized their lives. Though purely anecdotal, we were struck with the number of separations and losses in this sample, including deaths of family members and friends, leaving a question for us regarding immunological weakening.

What I am proposing is that we focus on attunement rather than explanation in treating patients with IBD, and that we consider the relationship system in which the patient is embedded as central to our frame of attunement. Patients who are physically ill are naturally more dependent

on the ministrations of family members and are thus particularly vulnerable to the interpersonal attitudes and projections of significant others.

### Case Example

In synopsis form I will describe a brief—six-session—extended consultation of a patient with severe Crohn's disease. My hope is to illustrate how attention to relationship context, an exploration of the interlocking unconscious and conscious communications between Janet and her husband, helped unlock some of the despair and constriction of Janet's adaptation to her illness.

Janet was referred to me by her gastroenterologist. She was described as having one of the most severe cases of Crohn's he had seen and though he had always wanted her to consult a psychotherapist, he had found her resistant until this last spate of illness. Janet was feeling defeated by a resurgence of symptoms 2 months after her seventh operation. Janet was 48, had been married to Jerry for 20 years, and had two grown children, one recently separated from her husband and relocated with her infant daughter in Janet's home. When I met her, she complained of constant pain, severe sleep disturbance, and depression about the futility of relieving or even adequately managing her disease.

Janet felt too ill to commit to an intensive treatment. She wanted some relief from her despair; she could not wait. I felt that I would have very little time with her and yet the extraordinary burden of her life moved me to hope that I would be able to provide some relief.

I met with Janet alone at first. She described her husband as alternating between caretaking and neglect (taking off for scuba lessons which were a Christmas present from her!) regardless of her state of health. However, above all, she described unremitting distress about any contact she had with her mother, who had briefly abandoned her children when Janet was a preteen. Most disturbing of all was that her mother could never remember the name of her illness, as though its recognition was beyond her narcissistic and entitled orbit. In our initial session Janet elaborated on every recent experience of maternal hurt and disappointment. Our conversation seemed to render her mother more indelibly distressing. At the same time, I noted that the description of her mother's behavior was laced with references to Jerry's total and absolute agreement with her portrayal.

I wondered whether "mother hating" might have a contextual as well as individual meaning. I asked if she and Jerry would attend the next session together to discuss her mother's impending visit.

When I met with them in a joint session, it seemed clear to me that Jerry inflamed Janet's rage. Why would a husband behave in this fashion? Might Jerry need to deflect Janet's anger from himself because he felt incompetent to relieve her suffering and hoped to avert the potential trajectory of her rage toward him? Did he believe that the most palpable help he could offer Janet was to echo and amplify every diatribe she hurled at her mother? Was he projecting "badness" onto Janet's mother to relieve himself of anxiety?

Following this hypothesis, I asked Jerry how he might increase his personal support for Janet. In fact, a discussion of improved caretaking seemed spontaneously to soften his assault on Janet's mother, and during the course of this session and the next, mother became less demonic for both of them. Was Janet's rage about her mother's dereliction suppressed? I think not. Because I view representations as fluid, I think that an increase in nurturance from Jerry led to a reduction in Janet's fury about her mother's unavailability. Moreover, Janet had likely inhibited Jerry's caretaking through her need to reenact deprivation.

A second issue I explored with Janet in our fourth session—the only other session I had alone with her—was her hypertrophic need to care for everyone. I wondered about this with her. Several dynamic hypotheses occurred to me: a compensatory wish to experience the nurturance she had lacked, a public defamation of her own mother's performance. However, we discussed her compulsion to care in terms of her here-and-now experience, a compulsion which generally resulted in her feeling exhausted and depleted.

Janet began setting limits on her children's emotional demands; she felt that she had "personal limits" for the first time, a new experience of self-care. In terms of the fluidity and the kaleidoscopic rotation of representations, it seemed that Janet's developing her own pattern of self-care served to further mute the representation of her mother as unbearably depriving.

Throughout this brief treatment, I referred to the absence of clear evidence for a psychological cause of symptomatology. I think this observation had a mutative effect on Janet's coping with IBD. Freed from a sense that she was utterly responsible for her symptomatology, Janet felt liberated to address the patterns of her self-care. This perspective had impact on Jerry as well. His customary stance was to blame Janet for flare-ups; her improper diet or activity level were the problem. When Jerry stopped blaming her for being sick, he looked more clearly at this own relationship participation.

Was there a reduction in Janet's symptomatology? No. Through the course of eight visits, spanning about 3 months, Janet's condition remained the same. However, one very significant change occurred in relation to her medical care. She became impatient with her physician, because she now believed that she was adequately caring for herself, both in mind and body. She felt she was not psychologically debilitated, was not somaticizing, and wanted relief. Her physician, basically sensitive and nonpathologizing, realized that her psychological efforts were somewhat successful, and began to face squarely his own frustration with her lack of improvement. He sent her for a second opinion—for the first time. Thus, our brief treatment had a rather broadband, larger systems effect.

A fundamental question raised by this consultation is whether awareness of relationship context would have been equally achieved in a brief individual consultation. For example, would Jerry's participation in Janet's frozen representation of her mother have been amenable to exploration? Maybe so, but I believe his collusion was more easily explored when both were present. It is more likely that Janet, alone, would have resisted an investigation of Jerry's displacement to her mother's indifference and neglect. I think his behavior, though part of her defensive system, would have been less accessible in his absence.

My experience in working with IBD—ulcerative colitis and Crohn's disease—patients has led me to admire those individuals and their significant others who evolve successful coping schemata and strategies. IBD patients have an enormous task required of them. They must manage ordinary developmental milestones while dealing with the repeated disruptions and trauma of an episodic illness. I think we do well to enter the arena of illness experience with a healthy measure of humility and naiveté and try our best to tolerate our anxiety and ignorance. As always, our psychoanalytic efficacy rests ultimately on attentiveness to the complexity and multiple realities of experience.

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