

Building bridges between body and mind: The analysis of an adolescent with paralyzing chronic pain

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This paper describes the evaluation, initial psychotherapy and subsequent psychoanalysis of an adolescent who presented with a severe psychosomatic process involving total body pain and profound fatigue. The author details the complex and multifaceted nature of the psychosomatic process as it unfolded in the treatment. The psychosomatic problem was not a single entity, but rather was comprised of diverse interwoven elements such as somatization, conversion on pre-oedipal and oedipal levels, conflicts over aggression, sexuality, identity, masochism, secondary gain, anaclitic depression, internalized self–other interactions with a depressed mother and transgenerational transmission of trauma. The author uses the case material to discuss technical approaches to problems that often arise in the analytic treatment of patients with complicated chronic pain and fatigue as the primary complaints. Such approaches include respecting the mind–body split as a primary defense, speaking the language of the body along with the language of the mind and developing the verbal sphere around the non-verbal symptoms. The author emphasizes that complicated chronic pain problems are common and can be helped by psychoanalysis as long as the unique and complex features are understood and reflected in the technical approach.

Keywords: Psychosomatic, pain, adolescent, fibromyalgia, psychoanalysis, somatization, mind–body split

Introduction

We all know that Freud's revolutionary theories were grounded in his clinical observations of adolescents and adults with psychosomatic problems like pain, paralysis and profound fatigue (1893). These symptoms of chronic pain and fatigue were, as far as we know, not associated with any medically defined disease. The conscious sources of distress for the patients were the symptoms themselves, and the treatment was the talking cure. Chronic pain and fatigue not associated with medically defined diseases continue to be common reasons for medical consultation in almost all societies, although the ascribed diagnoses have varied markedly with different times and cultures (Kleinman, 1980; Fabrega, 1991; Aronowitz, 1997).

Psychoanalysts have treated and continue to treat many patients with varied psychosomatic problems, such as inflammatory bowel disease, dermatologic conditions and eating disorders. However, a complicated confluence of historical, social and political factors has shaped practice patterns such that debilitating chronic pain and fatigue are typically defined by physicians, patients and the culture as purely or primarily biomedical conditions, rather than as

problems that involve both mind and body, intricately and complexly intertwined. Psychoanalytically informed treatment is often not even considered for patients who present with physical symptoms as the primary or only source of distress. When a referral to an analyst is made, many patients feel resentful and stigmatized, do not truly understand or agree with the referral, and leave treatment after a few sessions. Obviously there are exceptions (Coen and Sarno, 1989). These tend to be patients who, because of their psychodynamics, character and background, are more psychologically minded initially.

A good number of children and adolescents also experience chronic pain. The pain may be a transient developmental twist or a symptom of more major and enduring struggles. Debilitating chronic pain typically emerges during adolescence (Shapiro, 1995). As with adults, children with chronic pain are usually treated within a biomedical model, with extensive laboratory and radiologic testing, consultation with medical specialists, and assignment of a confusing and changing variety of medical diagnoses.

I discuss here the treatment of an adolescent who was referred to me because of debilitating chronic pain and fatigue. I describe the initial presentation, the psychotherapy, the conversion to analysis, and the process and content of the analysis, with a specific focus on those aspects relevant to the psychosomatic problems. I use the case material to illustrate two major areas: (1) the many psychic mechanisms and determinants of psychosomatic processes; and (2) techniques in working with patients who initially define their distress as primarily or only physical. In order to integrate the clinical narrative with theory and technique, I have interlaced the case material with more abstract discussion throughout the body of the paper.

The risk is that you will think a case like this to be rare—it is not.

First impressions

Kai was 13 when she was referred to me for constant severe total body pain. Because of the pain and fatigue, for several months she had been unable to walk, move any part of her body, feed or toilet herself, or care for her daily hygiene including her menstrual flow. She slept with her mother, and was fed, carried to the bathroom, held on the toilet, and washed by her family. Her medical workup was normal except on physical examination for muscular tender points and generalized weakness from inactivity, prompting a diagnosis of fibromyalgia. (Fibromyalgia is a chronic pain syndrome involving the muscles and tendons. It is a clinical syndrome without defined pathophysiology (Yunus and Masi, 1985; Hudson and Pope, 1989).)

In the first session, I opened my office door and saw Kai in the waiting room, slumped over in a wheelchair, head hanging, with no tone in her body except for the contorted position of her limbs. She looked directly at me, unsmiling and somber. Her parents were standing next to her, tense, speaking in hushed tones. I invited all three into my office. Her father picked her up from the wheelchair and put her into one of my office chairs. She cried out as he moved her, and then slumped to the side, head hanging. Her father described how any touch hurt her, and reached out to touch her arm with his finger. She promptly jumped and groaned.

Early in the first session I realized that previous health care professionals had focused on determining the ‘veracity’ (i.e. physiologic causation) of her symptoms. Kai’s symptoms were considered ‘real’ only if they were caused by medically defined disease. This focus occurs commonly in these situations and stems from a Cartesian dualism, in which mind and body are regarded as separate entities. It goes beyond dualism, however, because only the body is considered ‘real’ and worthy of attention. This way of thinking is common in our culture,

affects the manner in which physicians and mental health care professionals frame illness, and is especially problematic for patients with subjective symptoms without tissue damage or disease. It creates a paralyzing quandary of shame and guilt: it is better to have a serious medically defined disease than to be seen as a liar (or the parent of a liar). Patients and health care professionals become locked in battle. The physician is determined to prove that the symptoms are 'only in the mind', and the patient is certain that the body is the problem. A cycle ensues in which more and more tests and consultations are requested in a futile attempt to settle an impasse masquerading as a question.

The analyst must negotiate the intrapsychic, familial and systemic conflicts immediately, starting with the first session. The veracity of subjective reality must be clearly and quickly established. I attempted to show via the direction, wording, and tone of my questions and comments that Kai's symptoms were her own and not to be doubted, that pain beyond endurance could exist without disease, and that all feelings, thoughts and speculations about both body and mind were listened to with attention and respect.

I asked permission to speak alone with Kai. As soon as her parents left she appeared to sit a little straighter. Her first statement startled me by the insight and honesty: 'I'm not sure I really want to get better, and I feel bad about that'. I responded, 'Something about getting better must really terrify you'. After some discussion, I suggested that part of our work together was to make sure getting well would not be overwhelming. She agreed and spent the rest of the session talking readily in a weak voice about her experiences over the prior few months.

Kai emphasized immediately that she saw absolutely no relationship between her physical symptoms and her other concerns. I accepted her statement at face value. We established, however, that she wanted help with the pain and the state of her body and, at the same time and in an entirely separate sphere, had some other issues that she wished to discuss.

At this time, when speaking with Kai and her parents, I did not relate Kai's physical symptoms to emotional difficulties. Such speculations, unless carefully worded and tailored to the needs of the patient, are usually counterproductive in this phase of treatment. Often psychosomatic symptoms reflect a primary and defensive mind-body split (Winnicott, 1964), and linking mind and body confronts a major defense without the necessary preparative work. Premature confrontation or interpretation, even if correct, forces the patient and/or family to mobilize other defenses, or to seek other treatment, often in a biomedical venue. (In the case of a child, the defensive split may exist in the child, one or both parents, or any combination thereof.) Also, the stigma of emotional 'illness' may affect the evolution of psychosomatic symptoms, and consulting a mental health professional is laden with shame and resentment. Having the symptom in the body 'saves face' when shame and cultural stigma are powerful. The shame must be addressed before the body and mind can be bridged.

After they left, I mused that Kai was unusually intelligent, articulate and introspective, especially considering her age and condition. Although her appearance was outwardly startling, I could feel her warm interpersonal engagement. Kai was ready and willing to talk, and brimming over with thoughts and feelings. I did not see the empty desolate core so often present in, for example, adolescents with anorexia. Since I see many people with unusual and difficult psychosomatic problems, I felt comfortable recommending psychoanalytic psychotherapy.

With this picture of Kai, drooping and paralyzed, in mind, I will fast forward to a brief vignette at age 16, after ten months of psychotherapy and two years of analysis. She walked briskly into the session and sat on the couch in her usual position, in the seat closest to me. After showing me her new shoes, purchased shopping with a friend at the mall, she handed me a poem she had written. I read it aloud.

Two faced

Blazing warmth and comfort,
 Security and hypnotic rhythm,
 I relax you and heal the aches of your day.
 Scorching red poison, my limbs can kill
 Licking at your body,
 Flirting with your hair,
 I toy with you, and destroy you slowly.

She said, 'I couldn't believe the sexuality in it'. I said, 'And the destruction'. She agreed.

Development

Kai's parents were born in Asia, came from professional families and were college educated with graduate degrees. The customs and expectations of their culture played a large role in their marriage, which had problems from the beginning.

Pregnancy and delivery were normal. However, there was discord between Kai's mother and the father's family in the months before and after Kai was born. The family moved to the United States when Kai was 4 months old. Adjustment was difficult. The mother described moving from a situation in which she was surrounded by family members to almost total isolation and foreign customs. The father was at work most of the time. The older brother, 5 years old at the time, withdrew and would not talk with the parents. The mother's time and attention centered around helping him. Rapidly the mother became profoundly depressed. One day, during a parental session, she tearfully described her relationship with Kai as a baby: 'I fed her and diapered her. I wasn't angry—just crabby . . . I wasn't there . . .' Kai was breastfed for nine months and then abruptly weaned. The mother's depression began to lift when Kai was about 18 months old.

We begin to see some of the ghosts (Fraiberg et al., 1975) affecting Kai's mind and body: a child's inchoate awareness of family secrets, not to be told in words; the roles and choices open to women; and the conflicts inherent in maternal identification. The later analytic material repeatedly confirmed the regressive pull to be forever very young, without responsibility and unknowing of family secrets and tribulations.

Also, visualizing Kai as the child of a depressed mother made sense of the profundity and psychosomatic nature of her symptoms, her deep inner sadness, her difficulties in self and physiologic regulation, and her precocious adult-like thoughts and musings. As I got to know Kai and her family, I was impressed by their many strengths, and did not think the stress on the ego from adolescent reworking of conflicts could have produced such a total breakdown of psychic and somatic function without significant and diffuse pre-oedipal vulnerability.

Kai was a high honor student from first grade on, and well-liked by other children and teachers. She was very obedient and recalled few mischievous acts. Her school notebook was always organized, neat and complete. In a highly competitive and demanding school district, she was consistently in the advanced placement classes. School also brought problems in separation. Kai was troubled by headaches and abdominal pain. The mother described Kai as typically responding to stress with her body.

Pubertal changes started at age 11. Then, starting at age 12, a cascade of events occurred. First, Kai's brother left for college. Both parents, especially the mother, were saddened by his departure. Kai clearly stated that she did not miss him, but developed headaches. She was sent to a psychologist and learned self-hypnotic techniques that worked—for a time. Then Kai had her first menses, and a few months later her mother went back to work for the first time since Kai's brother was born. Kai developed pain that gradually spread throughout her entire body,

accompanied by debilitating fatigue. She could not attend school and her mother took a leave of absence from work. Kai's condition rapidly worsened and she became unable to move or care for herself. She could not lift a fork to feed herself, and could not use the toilet nor take a bath without assistance.

Her parents were understandably distraught and sought medical advice. The medical workup was long and extensive. Kai's pediatrician sent her to a psychologist. The psychologist thought there were no emotional components to the symptoms and recommended that the medical workup be pursued. After several months Kai was referred to me. By this time she was 13 and had been bedridden, barely moving, for months.

As this story unfolded, it did not take much acumen to hear problems with separation, aggression and sexuality, resting on and defended by a central, early and pronounced split between psyche and soma. However, of immediate importance was that Kai and her family were at risk of being caught in an ever deepening spiral of medicalization of her symptoms, accompanied by cascading erosion of adolescent development. Kai very clearly separated emotional responses from physical responses. Reflecting and exacerbating Kai's psychosomatic split was a split between the medical and mental health systems, each ascribing the problems to the other. Moreover, the parents themselves were split, both in their relationship and in their views of their daughter's symptoms. The father viewed Kai as either deathly ill or a malingerer, and the mother ascribed the symptoms to emotional stressors. These systemic and familial splits are common for patients with similar problems. I thought intervention initially would have to include the family and the medical system, as well as Kai.

The psychotherapeutic bridge to analysis

Kai, her parents and I agreed to ongoing once-weekly psychoanalytic psychotherapy, accompanied by an out-patient program at a rehabilitation hospital. Since she had barely moved for months, she had lost muscle strength and tone. Viewing this situation through Engel's biopsychosocial lens, psychotherapy, family work, physical therapy and a structured environment work together (1980). With Kai and her parent's permission, I contacted the other physicians to ensure that, as far as possible, splits within the system did not perpetuate intrapsychic splits beyond the time they were needed for defensive or expressive purposes. As in many situations like this, I needed to make only a few short calls. The purpose of calling the other health care professionals was simply to establish links and create a mental picture of collaboration in everyone's mind.

I worked separately with the parents, seeing them once-weekly at this stage of treatment. Faced with the physical and emotional burdens of providing total care for Kai, they needed help accepting the validity of her symptoms and her current experience of her body, while at the same time placing reasonable expectations and boundaries for Kai to assume her own physical self-care. We also needed to lay the foundation for them to support Kai's improvement when it came. It became clear how deeply troubled the marriage was, and that Kai's illness buffered the marital discord. I referred them for help. Although working with the parents changed some of their behavior and expectations, unconscious factors were powerful. The mother grew increasingly depressed as Kai improved, despairing over her marriage, her future, and also over traumatic events in her own childhood. When stressed, the father continued to think that Kai would never get better, and that only weakness of will could explain the symptoms. Gradually, however, Kai's need to justify her pain to her parents decreased.

Kai willingly explored the emotional realm as long as I respected her need to maintain psychosomatic separation. She discussed her drive for high achievement in school; her wish to

date and her firm belief that her father would not permit this; her resentment that her brother had not paved the way toward being American; her perception of her father as highly critical; her need for closeness with her mother; her fears of growing up and assuming responsibility for her actions; and many other aspects of her emotional life. Kai welcomed her sessions and used every minute to talk.

I listened as Kai described her physical symptoms at length. I tried, with my own body and senses, to get as accurate a picture as possible of her pain, fatigue and other sensations. She was very articulate, and used her poetic abilities to enlarge, via metaphor and descriptive images, the verbal space around her symptoms. I will give a reconstruction of one discussion as an example. She described in a weak voice her faltering attempts to stand up by herself. I asked her to tell me more about what it felt like. She described the kinesthetic sense of not knowing where her body was in space, fearing she would become disoriented and topple over when she was too far away from a wall: 'It's hard—I lose my balance—my body feels different in space'. She then told me how she would take very short steps, keeping one hand on the wall, and would hunch over to make herself shorter, feeling that her body was too tall in space. Her next association was to a baby beginning to stand and walk. I commented that, just as a baby's body feels different crawling and then standing up, so also Kai's body was actually different because she had grown and her body had changed in shape while she was sick. She had indeed grown by several inches and her breasts had matured.

In this way, presymbolic and symbolic non-verbal experiences and perceptions were gradually linked with and transformed into words and verbal metaphors, and held within the intersubjective space between us. The sensory descriptions were crucial (Bucci, 1997; Krystal, 1997). Although my ascribed role was that of a doctor of the mind, Kai saw that discussions voiced in the language of the body and in the language of the mind were equally welcome. So often people with these sorts of symptoms are pushed away from what they want to talk about, which is how they feel in their bodies. I have repeatedly heard mental health professionals describe their own preference for material considered reasonable for a psychotherapy session—the language of the mind. A parallel process occurs in the biomedical sphere, as physicians encourage discussions of tests, diagnoses and coping techniques, and steer away from the actual pain. People with these problems may seem centered around their bodies but this is a surface phenomenon, often hiding an inability to identify and react helpfully to signal body sensations.

The provision of physical therapy, which I often recommend in these situations, helped with the process of bridging the mind–body divide. Clearly, if there are problems like muscle wasting from inactivity or painful muscle spasm, movement is necessary for recovery. However, in addition to its concrete physical effects, physical therapy, in a process akin to the development of a body ego, builds a mental picture of the body and provides a forum for attention to body sensations and signals, which are then brought into the analysis. Also, the need for selfobjects for regulation is often acute for patients severely disabled by these symptoms, and physical therapy provides additional regulators specifically focusing on the actual body (Taylor, 1987). If a team approach is utilized, a holding environment which straddles the mind–body split is created. This was my aim with Kai.

Over time, Kai slowly started to move. After six months she returned to school part-time. Her heart pounded, she was short of breath and was unable to open her eyes in the morning. Her pediatrician examined her with the occurrence of these new symptoms. Initially he tended to pursue an unnecessary medical workup, which further reinforced Kai's perception and fear of physical illness. After he and I briefly discussed the situation, he reacted to new symptoms with a careful physical examination, but without laboratory or radiologic workup.

These new symptoms provided an entry into Kai's psychosomatic split. Previously I had respected her strong defensive need to separate her body from her mind. To do otherwise would have foreclosed the eventual inclusion of presymbolic somatic material in the therapeutic work, mobilized stronger defenses and destroyed the continued development of an alliance. The new symptoms, however, expressed her somatization *in statu nascendi*. Since we had built, over time, a verbal symbolic realm around her physical expressions, verbal confrontation and interpretation were credible. I called Kai's attention to relationships between body and mind. I stated my belief that her symptoms represented, in part, the physical aspects of emotion. I wondered whether her emotional pain, anxiety, anger and sadness were so overwhelming that they were channeled into her body. She rolled her eyes and disagreed. We then agreed that perhaps the truth lay in both our views—that her story could be told in the language of the body or in the language of the mind. I recommended to her parents and physicians, all of whom now saw the symptoms as related to anxiety, to state their beliefs while giving Kai the right to express her own thoughts, in her own language. She began to not always hear the correlation of psyche and soma as an accusation or an impossibility. The agreement that the same phenomenon could be understood and described differently by the two of us was key (Graham, 1967).

After Kai regained full function in most activities, we discussed how to proceed. Her parents were concerned that Kai's symptoms could recur without more treatment. Kai herself wished to intensify the treatment, although in the same breath she denied any contribution of emotions to her illness. She had the intelligence and education to view mind and body as interactive, and had a family model for doing so. Thus the mind-body split was not purely cognitive or cultural. I was struck by her access to and ability to explore her inner world. In my experience, other adolescents with similar psychosomatic problems often tend to be verbally and emotionally constricted, at least initially, fitting the concept of alexithymia (Krystal, 1997). Kai and her parents accepted the recommendation of psychoanalysis as the treatment of choice.

The analysis

Throughout the analysis Kai's sessions were full of material, often eloquently and poetically stated. She always sat on the couch in the seat nearest to me, sometimes fidgeting with her hair or clothes. At the beginning her body was tense and she looked at me frequently, clearly very aware of and responsive to my non-verbal reactions. I felt observed and tense myself. Sometimes her sidelong glances my way were accompanied by a giggle. Other times her lower lip protruded and her eyes rolled, but politely and ever so slightly.

For months, starting the sessions was difficult for Kai. She would hesitate, look at me repeatedly, giggle and, eventually, fidget. We developed a game. I said once, 'A penny for your thoughts'. She looked at me, smiled and replied with a laugh, 'Really? Then where is the penny?' I produced a nickel. For the next month, the nickel possessor had power over the flow of dialogue. She who possessed the nickel could choose to hand it to the other person, who then would have to break the silence. Over time, we began to see some of the dynamics underlying silences. She described how she avoided talking about certain things. She feared my rejection were she to take the first step. Her thoughts and feelings were immobilized, just as her body had been immobilized. I told her that her wish to please was crippling to her body, and that waiting for me to begin gave her some perception of control. If she made me start, then she would not feel controlled by me. As we gained understanding the nickel faded from the picture.

Self, dyadic and triadic material, with hues of aggression and sexuality, emerged in a session revolving around Kai's troubles with geometry. She had mentioned her problems understanding

certain geometrical concepts. Initially I made no move to explore the actual geometry problems, focusing more on her envious and competitive feelings toward her classmates and her relentless perfectionism and self-demands projected on to her teachers. During one session I suddenly realized that my own feelings involving math and geometry had obscured my vision. I had assumed that she would of course have trouble with geometry. The analyst and analysand together, with unconscious craftiness, managed to elude direct and specific vision.

I asked Kai to tell me more about the actual geometry problems. She described the one she always got wrong, always in the same way, time after time, test after test. The offending problem involved calculating the reverse angle in clocks.

A: Anything about clocks or time or angles?

P: It's something to do with figuring the time backwards . . . I always wish it were this time or that time, and not the time it is . . . always wishing for the best time but it never happens . . . I wish I could push the clock back to being a baby—maybe to last year when I was sick . . . I hated being sick, but it was just me and my family . . . I felt protected, close, like a baby would feel. [She abruptly looked at me, eyes wide and stunned.] You don't think that's why I'm having trouble?

A: What do you think?

P: No. It can't be. [She continued to ponder out loud.]

A: [Waving at the clock.] Speaking of time, it is time.

P: [Kai looked at me, startled and then reproving.] I hate that. How can you interrupt such a pensive moment? [As she stood up, her shoulders slouched and she shot me an angry glance.] Now I have to do my homework!

Walking toward the door she slouched more, her face crumpled, she looked down and grabbed her stomach. 'My stomach hurts', she whisper-wailed as she walked out the door.

In this short vignette, we see enactment (enabled by my blind spots) and themes of separation, dependent longings, aggression and sexuality. Her rage at separation was followed by a defensive somatization. With the psychosomatic learning problem, I hypothesized, based on data from other sessions, repressed awareness of Kai's female body—the problems with geometrical location and shapes (Lerner, 1976). The defensive somatization—her stomach ache—could be conceived as: (1) a symbolic conversion of unacceptable dependent longings and rage to an organ associated with nurture and receptivity; (2) the somatic expression of a psychophysiological affective response, with attention defensively and regressively focused on the somatic aspects; and (3) a masochistic and passive-aggressive expression of transferential rage, automatically expressed as pain in a manner likely to arouse my guilt and sympathy (which it did). We can visualize the actual organ, the stomach, remaining inert, with the reactivity in her brain-mind, or we could speculate that the neurophysiology of shifts in affect were reflected in gastro-intestinal spasm and pain as well as central nervous system changes. Research supports the idea that affect changes gastric physiology and motility, as the brain and the gastro-intestinal tract share many neurotransmitters and are intimately linked neuroanatomically (Boyce and Jemerin, 1990; Porges, 1992). I believe, based on evidence from her analysis, that all the mechanisms listed above occurred during this short interaction.

The extent of Kai's sadness and anxiety gradually became evident. Often her eyes would glisten. When I referred to her tears, Kai corrected me and said that the water was 'allergies'. I wondered whether it was easier for her to talk of allergies than of sadness, and where the actual tears were if these were allergies. Finally, in a particularly poignant session, Kai openly cried for the first time without calling the tears 'allergies'. 'Things just aren't perfect', she lamented,

wiping her eyes. I commented on how hard she worked to keep the sad feelings away. 'I think things but don't talk', she replied. 'I cry for no reason. I don't want to keep things in. I just don't want to talk about them.' She gulped a few times, swabbed at her eyes with her fists and then looked at me. 'Will it take a year for my pain to go away? How long will I feel so sad?'

For many months Kai denied any difficulty separating from her mother, and insisted that her inability to spend the night at a friend's house was because she was too sick. I addressed her shame over dependent longings. Eventually she explored her fears of being alone. We began to see how these difficulties had existed for years. Kai described how she could not go to sleep unless her mother was awake and by her side. She vigilantly guarded against the state of relaxation necessary for sleep. If the mother fell asleep at her side, Kai felt furious and found some way to wake her. She then remembered how, when she was little, her mother would sit by her side exhorting her to sleep. If Kai appeared that she was not earnestly trying to go to sleep, the mother would become angry and leave. If she fell asleep, her mother would slip away, and Kai would awaken with a start, finding herself alone. Thus Kai tried to look as if she were trying to sleep when actually she was trying to stay awake.

As Kai reminisced about these experiences, I remembered the many months before we started analysis when she was neither walking nor moving. During that time, she often demonstrated how she was trying to walk and move. I would watch her 'try', struck by the sheer opposition of her efforts, and would find myself sympathetically understanding the frustration and anger of her physical therapists. It appeared that she was trying to look as if she were trying to move, while she was trying, in fact, not to move. I noted to Kai how she was trying to sleep and not sleep at the same time, each for very good reason, and wondered if she felt the same about other aspects of her life—like when she was not able to move. We discussed how powerful opposing conflicts had literally immobilized her. I believed we were approaching the conscious and preconscious defiance inherent in her symptoms. Kai noted the incompatibility of wanting to do things her own way and of being totally dependent. I said to her that one solution to this terrible dilemma was to be dependent in her own way, while at the same time expressing her anger by punishing and rendering helpless those around her. I noted her shame and guilt over this solution.

As the analytic realm expanded, Kai's problems in self-care and regulation—both somatic and psychic—became evident. Her illness represented an extreme regression. The regression defended against conflicts around sexuality, aggression, independence and autonomy. However, her analytic material also pointed to early developmental lacunae. Kai described problems with changing pace, activity or state in many spheres. For example, starting her homework was difficult and even dreaded. Once she began the work, however, she would not stop, even to stand up and stretch. After sitting still for so long her muscles would cramp. She would then be in pain and very fatigued. Eating and hunger were also problematic. She would be hungry, but then would lose the hunger before eating much, or would forget to eat at all. Sometimes she would become dizzy from going without food as she was not aware of hunger pangs. Other times she would eat by rote, unguided by appetite. (Note: she had no distortion of body image. Her eating was disordered but she did not have anorexia nervosa.) Even her regulation of body temperature was skewed. She became cold easily, sometimes shivering, and was unable to identify whether she was truly cold, anxious, panicked or just had not moved her muscles. Her mother described (and I saw) how her peripheral circulation in her hands and feet would constrict, blanching her brown skin. I believe she had deficits in self-awareness and regulation, as is true of so many people with profound psychosomatic problems (Khantzian and Mack, 1983; Taylor, 1987; Krystal, 1997). She was not able to identify signal affects and sensations, and so self-regulation of state, affect and sensation tolerance were impaired. I noted to her that

her body spoke and she did not listen. We explored what her body felt, and how she could listen and moderate her activities.

We talked about how Kai avoided crying in front of her mother and me. She said that if she cried then her mother would cry too, and then described the exploding and fragmenting desperation she felt when seeing her mother crying or sad. I saw this as, in part, related to her experiences as a baby with a depressed mother. I commented that she held back her tears to protect others, to the extent that she did not even feel her own sadness nor feel tears as tears.

She said one day, 'Maybe my body cries—like shivering'. (I had previously pointed out her frequent shivering responses, and wondered if these were associated with the material we had been discussing.) Her curiosity was piqued, and over the next months she alternated between examining her somatic responses and dismissing somatic reactions as 'only' the cold or her muscles. One day she complained that her legs hurt. I wondered, based on preceding material, whether her body was trying to say something and the feelings were locked away in her legs. She stared at me, clenched her arms across her chest, looked off in the distance with a frightened look on her face and shivered: 'Did you ever know something and not know it? . . . I know now that I'm so scared of school—being alone . . . is this an anxiety attack?' I said that it was, and that the anxiety was shifting into her body rather than into words. She said, 'I might fail . . . or I might do too much'.

After about a year, Kai shyly and hesitantly confided that during her illness, when she was unable to move, she had many feverish fantasies about boys: 'I was in another state . . . it was like a series of dreams . . .' She avoided being specific. Slowly sexuality emerged more and more in metaphor. She related a dream in which *she was in a wheelchair, with a beautiful silver skirt shining in the moonlight*. (She had not actually used a wheelchair for over one year.) After recounting the dream she described feeling that there was a special muscle, somewhere below the small of her back—'an elusive place—I can't find it—a missing part I want to stretch'. I commented that the silver skirt in the dream was hidden in the wheelchair and the elusive muscle that wanted to be stretched was also hidden and not yet found. A few weeks later she went for the first time to a dance, and 'could have danced all night . . . my heart was vibrating to the music'. This was a major step forward, and was followed by increased physical symptoms—fatigue and pain—for about one week. In posture she assumed her prior slouched and hunched position, in which her breasts could not be seen and she appeared angular and unattractive. She physically obscured her sexuality and attractiveness.

Kai talked frequently about being an emigrant. She described her native country, which she had visited many times with her parents, in glowing terms—painting evocative pictures of the flowers, the scents, the colors, the heavy warmth of the air. In that place, she said, one was never lonely. There were always other people around—lots of other people and, if one was not getting along with one person, there were many others with whom to talk, share and be. She viewed the state of affairs in America as quite different. Families lived isolated lives in separate houses and separate bedrooms. 'Children over there don't have teddy bears and other things like that—they always have people around. When you have people you don't need teddy bears.' She wanted it all—to have people around whenever she wanted, and also to have privacy and her own teddy bear. She spoke of disliking the native food. Indeed, during every trip Kai had become sick, unable to eat, and lost weight. She thought all this over and then said, 'There my body is not at home. In this country my mind is not at home'. Her mind-body split spanned the continents.

I viewed the cultural aspects of Kai's material as multifaceted, representing, among other issues, idealization and loss of an incompletely experienced and longed for nirvana, as well as conflicts in her adolescent reworking sense of self, ego ideal, separation and individuation, and

oedipal themes (Akhtar, 1999). Prominent in these conflicts were variations in modes and degrees of separation and individuation. Was she to be merged or was she to be autonomous? She wanted both at the same time, and the only way to obtain both was to regress to a fantasied omnipotent state. In this regressed state she avoided facing the reality that she could not be all things in all ways. Oedipal level conflicts were also embedded in her struggles over culture. Clearly Kai had the intelligence and ambition to pursue higher education and a career. However, such achievement represented a terrible loss of the symbiotic mother. Her perception of her father as forbidding sexuality was in part her own projection and in part reality. Her initial symptoms rendered her both incapable of achieving (at school) and unattractive, so that she would not have to face these unthinkable conflicts.

As we moved on, Kai began to identify her suffering as emotional. The sadness and depression at times became overwhelming. Her paternal grandmother died unexpectedly and Kai plunged into a deep depression. Since she had not been particularly close to her grandmother, the depths of her feelings were a mystery to her, her parents and me. I told her this appeared to be about more than her grandmother, and perhaps had to do with strong feelings that had been around for quite a while. One day she came in with a tape containing a song which she said 'makes me feel exactly as I felt when my grandmother died'. She played the song, which was a sad plaint of loss, abject loneliness and emptiness, with a reference to the light fading into darkness. After playing the song she said, 'I know now that it was not just my grandmother, but I don't know what it is'. I suggested that she see where her mind took her. She jumped slightly, looked apprehensive and then said abruptly, 'I just remembered that when I was little, when my mother thought I was asleep, and I wasn't but I would be pretending, she would get up, turn off the lights, go out and close the door. It was like I wasn't there.' Her eyes opened wide and silent tears poured down as she looked into the distance. I said something about how hard it might be to see the lights going off, like losing the light of herself in her mother's eyes. She broke into sobs. I felt the tears in my eyes.

This and other material pointed to the lasting effects of Kai's experience as the baby of a depressed mother. This, of course, has been discussed by many authors (Stern, 1995; Beebe et al., 1997; Tronick and Weinberg, 1997), along with the correlation of early trauma with chronic pain syndromes (Wasserman et al., 1988; Malleon et al., 1992; Schofferman et al., 1993; Gruneau et al., 1994).

I will discuss some of the psychosomatic effects. First, infants learn to regulate psychophysiological states by internalizing good-enough dyadic regulation. Critical psychoneurophysiological pathways are formed (Schore, 1994), affecting all aspects of the nervous system, including the autonomic nervous system. Self-regulation involves regulation of the autonomic nervous system. Hyperarousal of the autonomic nervous system is in itself correlated with a decreased tolerance for sensation, in which touch becomes painful, as in reflex sympathetic dystrophy (Geertzen et al., 1998). Second, a well-meaning but depressed mother, although not able to attend fully to the baby's psychic needs, does, as did Kai's mother, attend to physical needs. Thus somatic expression becomes an effective mode of communication and means for interaction. Third, the vicissitudes of separation and the Oedipus may become insurmountable when the capacity for psychophysiological regulation is not age and phase-appropriate. Fourth, the child is rageful, but fears destroying a fragile mother. The expression of aggression is diverted into somatic, masochistic, or passive aggressive pathways. Fourth, the baby may identify with the mother's depression. Finally, depression is a psychophysiological phenomenon; the somatic effects of diffuse pain and profound fatigue are well-known.

Going back to the clinical material, Kai and I saw the ways she handled her anger. For example, one day she asked whether I had thought she was 'clinically depressed'. (She was

learning about depression in her psychology class.) Since we had used the word ‘depression’ in the past, I was puzzled, and attempted to understand her concerns and her wish to get me to say the words. Rapidly her face became stormy, her lower lip protruded and her chin jutted out. She proclaimed that she was now feeling miserable, just as she had in the past. As the session proceeded she looked more and more miserable and I felt increasingly helpless. When we ended she said, with a flash of her eyes, ‘See, you made me this way’. The following session, she walked in looking miserable and announced that she was depressed, just like before. After some discussion, I told her that people didn’t become depressed in fifteen minutes, and that I thought she was reacting to something in the last session that made her angry with me. Her face cleared, she sat up straighter and described picking a fight with her mother after the prior session. She told how she put on her ‘stubborn face . . . the face I know makes my mother mad . . .’, and demonstrated to me how she made this face by sticking out her lip and clenching her jaw ‘. . . just like this . . . I wanted to get her . . . I wanted to make her mad’. She then described how angry she got when she perceived her mother as ‘depressed’, how guilty that anger made her feel, and how she then would express the anger passively by putting on ‘my face’ to make her mother feel angry and guilty herself, or by complaining of pain and hunching her body into a miserable state.

We continued to gain more understanding of her symptoms. Kai remembered that, right before she got sick (‘sick’ had been her word), she was placed on a highly advanced academic track, which would have involved college courses during high school. She recalled her feelings at being placed into a seemingly irreversible and terrifying process, and questioned whether her symptoms were an attempt to avoid this. Immediately she expressed her guilt over this, recognized the guilt, and stated that getting sick with the symptoms would have been one of the few things an obedient girl of her age could do. ‘How could I possibly have told my father I didn’t want this? How was I to know that I didn’t want this? I couldn’t have said no.’

Throughout the analysis, there were external forces acting on Kai’s ability to let herself feel better. In my work with the parents, the therapeutic alliance with the mother was solid, based on understanding of the need for analysis and the process. However, the therapeutic alliance with the father rested more on his fears of his daughter’s relapse. Although he was philosophically minded, and loved his daughter deeply, he was not psychologically minded, and had to work hard to understand the process. Kai recognized this: ‘I have to act sick so my father doesn’t start asking me when the analysis will be over’. I worked with him to understand how it was not helpful for him to react to improvements by talking about stopping.

We planned termination when Kai was 18 and entering her first year of college. We knew that she was vastly improved but that her struggles were not over, and that she might or might not need to come back.

It has now been over two years. I have seen Kai several times since termination, but that is another story.

Discussion

Kai’s case illustrates some ways to think about technique when working with people who identify their distress as primarily physical or biomedical. There is no doubt that some of these patients benefit greatly from analytic treatment, as did Kai. However, they often require a preparatory phase (Bernstein, 1983), during which pain as a physical experience and pain as an emotional phenomenon are drawn together. This preparatory phase may span a few minutes or a few years. Key aspects of the preparatory phase with Kai included respecting the mind–body split as a primary defense, avoiding premature confrontation, listening and speaking the

language of the body as well as the language of the mind, and slowly developing a verbal transitional space around the non-verbal symptoms. Also, a biopsychosocial frame for the treatment and for the role of the analyst made possible the integration of psychotherapy, physical therapy and other medical approaches, a structured milieu, and a multidisciplinary team approach in the beginning phases.

In addition, Kai's analytic material demonstrates the developmental and dynamic complexity of psychosomatic problems. Her symptoms could not be understood as just oedipal, pre-oedipal, pre-object related or adolescent; as just conflict or deficit; as just trauma, development or compromise formation; as just conversion, hypochondriasis or somatization; as just dissociation or repression; as just rooted in self-psychophysiological regulation or object relationships; as just intrapsychic, familial, constitutional or cultural; as just expressive or defensive; as just depressive, aggressive, sado-masochistic or hysterical; as just conscious, preconscious or unconscious. The analytic material showed clearly, again and again, that her symptoms were, in fact, all these things and more.

The relationship between body and mind has been discussed by many philosophers and psychoanalysts (Descartes, 1642; Winnicott, 1964; Graham, 1967; Engel, 1980; McDougall, 1980; Scarry, 1985; Coen and Sarno, 1989; Wilson and Mintz, 1989; Hogan, 1995). There are multiple theories, each with proponents and critics. From the viewpoint of clinical utility, I suggest that most major theories of mind-body interaction have their place. One particular theory may have explanatory and therapeutic value for one situation, one session, one dream, and not for another. Adhering to one paradigm of mind-body interaction and avoiding another may supply an illusion of safety at the cost of dynamic range and flexibility. It may be that each of the major theories of mind-body interaction, including dualism, parallel linguism, unity and materialism, arises from understandable and ubiquitous human experiences, both conscious and unconscious, of how mind and body go together.

As analysts our own feelings and fantasies about how minds and bodies relate inevitably affect our choice of words; the degree to which we inquire about and listen to physically expressed symptoms; affects and fantasies; the framing of our role to the patient; our ability to use physical language for as long as is necessary; and our comfort and interest in working with people like Kai with highly complex psychosomatic problems.

Translations of summary

Brückenbauen zwischen Körper und Psyche: die Analyse eines Adoleszenten mit lähmendem chronischen Schmerz. Dieser Artikel beschreibt die Evaluierung, anfängliche Psychotherapie und anschließende Psychoanalyse eines Adoleszenten, der sich mit einem schweren psychosomatischen Prozess präsentierte, was Schmerzen am ganzen Körper und schwere Müdigkeit einschloss. Die Autorin stellt die komplexe und vielseitige Art und Weise des psychosomatischen Prozesses dar, wie er sich in der Behandlung entfaltet. Das psychosomatische Problem war nicht eine einzelne Einheit, sondern setzte sich eher aus verschiedenen miteinander verwobenen Elementen wie Somatisierung, Konversion auf präöidipalen und öidipalen Ebenen, Konflikte mit Aggression, Sexualität, Identität, Masochismus, sekundärem Gewinn, anaklitischer Depression, internalisierten Selbst-Anderer Interaktionen mit einer depressiven Mutter, und Transgenerationenübermittlung von Trauma zusammen. Die Autorin benutzt das Fallmaterial, um technische Ansätze zu Problemen zu diskutieren, die oft in der analytischen Behandlung von Patienten mit kompliziertem chronischen Schmerz und Müdigkeit als ihren primären Beschwerden auftreten. Solche Ansätze beinhalten das Respektieren der Psyche-Körper Spaltung als einer primären Abwehr, das Sprechen der Körpersprache neben der Gemütsprache und das Entwickeln einer verbalen Sphäre um die nonverbalen Symptome herum. Die Autorin betont, dass komplizierte chronische Schmerzprobleme häufig sind und ihnen mit Psychoanalyse geholfen werden kann, so lange wie die einzigartigen und komplexen Merkmale verstanden und im technischen Ansatz reflektiert werden.

La construcción de puentes entre cuerpo y mente: El análisis de un adolescente con dolor crónico

paralizante. Este artículo describe la evaluación la psicoterapia inicial, y el subsiguiente psicoanálisis de un adolescente que presentó un proceso psicósomático severo que involucraba dolor corporal total y profunda fatiga. La autora detalla la naturaleza compleja y de multi facético del proceso psicósomático que se desarrolló en el tratamiento. El problema psicósomático no era una sola entidad, sino que comprendía diversos elementos entrelazados tales la somatización, la conversión en niveles pre-edípicos y edípicos, conflictos alrededor de la agresión, la sexualidad, la identidad, el masoquismo, la ganancia secundaria, la depresión anaclítica, las interacciones internalizadas del ser y con el otro (con una madre deprimida), y la transmisión trans-generacional del trauma. La autora utiliza el material de caso para discutir los enfoques técnicos frente a los problemas que surgen con frecuencia en los tratamientos analíticos de pacientes con dolor crónico y fatiga complicados, como dolencias primarias. Tales enfoques incluyen respetar la escisión mente-cuerpo como defensa primaria, hablar el lenguaje del cuerpo junto con el lenguaje de la mente, y desarrollar la esfera verbal alrededor de los síntomas no verbales. La autora enfatiza que los problemas complicados de dolor crónico son comunes y pueden ser aliviados por el psicoanálisis, siempre y cuando se comprendan los rasgos únicos y complejos, y que el enfoque técnico los refleje.

Faire le pont entre le corps et l'esprit : l'analyse d'un adolescent souffrant de douleur chronique paralysante. L'article décrit l'évaluation, la psychothérapie initiale, et la psychanalyse qui a suivi d'un adolescent qui présentait une sévère affection psychosomatique, entraînant des douleurs dans tout le corps et une intense asthénie. L'auteur détaille la nature complexe et multiforme du processus psychosomatique tel que celui-ci s'est déployé au cours du traitement. Le problème psychosomatique ne constituait pas une entité homogène, mais comportait plusieurs éléments intriqués entre eux : somatisation, conversion à des niveaux oedipiens et pré-oedipiens, conflits relatifs à l'agressivité, sexualité, identité, masochisme, bénéfices secondaires, dépression anaclitique, interactions intériorisées soi – autrui avec une mère déprimée, transmission transgénérationnelle du traumatisme. L'auteur utilise le matériel clinique pour discuter les approches techniques des problèmes qui apparaissent souvent dans le traitement psychanalytique de patients présentant une douleur et une asthénie chroniques comme plainte principale. Ces approches nécessitent de respecter le clivage esprit – corps en tant que défense primaire, de parler le langage du corps parallèlement au langage de l'esprit, et de développer un environnement verbal autour des symptômes non verbaux. L'auteur souligne que les problèmes de douleur chronique compliquée sont fréquents, et peuvent être aidés par la psychanalyse, à la condition que l'approche technique prenne en compte et reflète leur caractère complexe et particulier.

Costruire ponti tra il corpo e la mente: l'analisi di un paziente con dolore cronico paralizzante. Quest'articolo descrive la valutazione, la psicoterapia iniziale e la successiva psicoanalisi di un adolescente che presentava un grave processo psicósomático, implicante sofferenza fisica totale e profonda stanchezza. L'autrice descrive minuziosamente la natura complessa e sfaccettata del processo psicósomático rivelatasi nel corso del trattamento. Il problema psicósomático non era una cosa a se stante, ma era costituito da elementi diversi intessuti tra loro, quali somatizzazione, conversione a livelli edipici e preedipici, conflitti relativi ad atti d'aggressione, sessualità, identità, masochismo, benefici secondari, depressione anaclitica, interazioni interiorizzate Sé-altro con una madre depressa e trasmissione intergenerazionale del trauma. L'autrice utilizza il materiale del caso per discutere gli approcci tecnici al problema che spesso insorge durante il trattamento psicoanalitico di pazienti il cui disturbo principale sono una complicazione di sofferenza fisica e stanchezza. Tali approcci comprendono il rispetto della dissociazione tra mente e corpo come difesa primaria, parlando il linguaggio del corpo assieme al linguaggio della mente, e sviluppando la sfera verbale attorno ai sintomi non verbali. L'autrice sottolinea infine che i complessi problemi del dolore fisico cronico sono comuni e che si possono curare con la psicoanalisi a patto di capire e di rispecchiare nell'approccio tecnico le loro peculiari e complesse caratteristiche.

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