Psychotherapy of Psychosomatic Anxiety Responses

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Abstract

Psychotherapy of psychosomatic disorders in adolescents is one of the most responsible tasks that the therapist could undertake. The psychosomatic spectrum of disorders in children between the ages of 5 and 18 is wide. The similarity between the individual symptoms lies in the fact that they are masked satisfying desires, but not in an adequate, but in a neurotic way. In the process of psychotherapy should be approached individually and take into account the personal characteristics and character traits of adolescents. This article discusses some of the most common disorders, as well as the reasons that caused them. The focus is not on eliminating the symptom, but on the cause.

Keywords: psychotherapy, symptom, psychosomatic disorders, psychoanalysis, anxiety, aggression.

1. Introduction

Psychotherapy of psychosomatic disorders in adolescents is one of the most responsible tasks that the therapist could undertake. The psychosomatic spectrum of disorders in children between the ages of 5 and 18 is wide. The similarity between the individual symptoms lies in the fact that they are masked satisfying desires, but not in an adequate, but in a neurotic way. In the process of psychotherapy should be approached individually and take into account the personal characteristics and character traits of adolescents. This article discusses some of the most common disorders, as well as the reasons that caused them. The focus is not on eliminating the symptom, but on the cause.

2. Method

Psychotherapy of psychosomatic disorders is a responsible process and in most cases works with the painful awareness of the fact that a person is a bearer of self-degrading memories, intentions, traits and this is alarming. The desire to be saved from it acts as a motive for pushing out painful information. This repressed information, as well as the ongoing process of repression, has an unconscious nature, but for all of them, there is inherent evidence confirming their real existence. The leading part of this evidence is “uninvited, unsympathetic guests,” which Freud called “symptoms.” Methods of the most popular psychological theories are used for the aims of this report. The task of psychoanalysis and psychotherapy is to reveal specific manifestations of
the relationship: repressed painful information – its specific conscious manifestations (symptoms).

In adolescents, unsatisfied desire causes frustration with an even stronger magnitude than in adults, and as a result, the child feels helpless and powerless. The natural emotional response to a blocked or thwarted desire is the appearance of anger as a pleasurable relief of the frustration process. Anger is the only tool by which a teenager can regain “power” over the situation (Wirsching, 1984).

In many cases, for one reason or another, it is difficult to express the spectrum of emotions experienced, because the nature of anger is of the “caliber” of the attacking emotions. When he is suppressed, along with the desire, he attaches himself to the Self and attacks it in parallel. The pronounced symptoms are the result of the attack on the Self (Peseschkian, 1977).

In the human psyche, no desire is denied: when it is impossible to fulfill and realize in the parameters desired by the Self, it is fulfilled in the form of psychosomatic symptoms. The paradox is that it is difficult to part with even some of the most painful symptoms because they are his satisfied needs. Due to the process of suppression of anger described above and since the symptom that appeared afterward is a satisfied desire, rules are formed regarding anger and symptoms, which indicate the following points:

• Where there is repressed anger, along with repressed desire, not only will there be symptoms, there must be symptoms;
• Where there is no repressed anger and repressed desire, not only will there be no symptom, but there can be no symptom;
• Where there is a symptom, not only will there be suppressed anger along with suppressed desire, but there should be suppressed anger with suppressed desire;
• Where there is no symptom, not only will there be no repressed anger and repressed desire, but there can be no repressed anger and repressed desire.

Despite the individual approach to each case of psychosomatic manifestation in adolescents, what they have in common is the reason for the appearance of anger, which lies behind the question “who?” In some cases, when the answer to “who?” In human equivalent is absent, then the target of this anger becomes the Self. This autoaggressive response gives rise to psychosomastics (Ringel, 1978).

When the target of anger is identified and this emotion is subsequently realized, then the anger disappears more easily in the process of psychotherapy. This process takes place by involving anger in “actively doing and doing something” related to the original desire. These actions accelerate the erasure of the symptom. The active participation of man puts him “in front of the line” – in a real place, outside the space “behind the line” – i.e. beyond the withdrawal in which the symptoms of the psychosomatic spectrum reside.

When the symptom is the result of implosion, due to anger directed at the Self, and given the high levels of magnitude, intensity, penetration, and chronicity of this anger, the maximum irradiation of the psyche involves overcoming the symptom by adding medication (Langen, 1968).

Anxiety caused by this whole process is a symptom in itself. The alarm is experienced in a specific way in adolescents. The above contingent between 5-18 years. deliberately avoids talking about painful and repressed topics, which are the roots of the angry and anxious reaction. In the psychotherapy office, the client performs a verbal account of the anxiety experienced.
Verbalizing his emotion, a person is verbally “poor” in terms of experiences, even in terms of facts, due to the unconscious desire to suppress the rising anxiety (Jores, 1981).

My psychotherapeutic practice testifies to a directly proportional connection between personal anxiety and the manifestation of verbal and bodily aggression. The individual rebels against anxiety and this forces him to include aggressive behaviors in his behavioral repertoire. Therefore, the registration of such forms by the psychotherapist should be assessed as a sign of unconscious interest in blunting anxiety, which is based on repressed predecessors. All my hypotheses about the above were confirmed based on a study of 150 adolescents between 5 and 18 years of age to which the following methodologies were applied:

- Spielberger Self-Assessment Scale;
- Bus-dyurki aggression test.

3. Results

After an applied correlation analysis between the levels of personal anxiety and verbal aggression and personal anxiety and physical aggression, a proportional relationship was established in both directions. After analysis of the results of the applied statistical procedure, using the SPSS software, the presence of a significant, strong proportional relationship between personal anxiety and the manifestation of verbal aggression ($r=0.585; \text{sig}<0.001$) and a proportional relationship with the presence of a strong and significant relationship between personality anxiety and the manifestation of physical aggression in the studied 150 adolescents undergoing psychotherapeutic process ($r=0.586; \text{sig}<0.001$), where “r” is a correlation coefficient and “sig” determines the significance of the correlation. The obtained results are a contribution to the work of the psychotherapist, due to their statistical significance, relative to the whole population, and not only to the specific sample ($\text{Sig}<0.005$).

The available psychosomatic symptoms, based on which the results discussed so far are derived, include a wide range of disorders, including those of an “implosive” nature, such as schizophrenia, personality disorder, affective and depressive disorders (Freud, 1956).

In psychotherapy with adolescents, the deep connection between traumatic childhood experiences and current behavioral manifestations in the form of clearly expressed symptoms has been established. The process included a family psychotherapeutic intervention, and with 10 of the families, the work continues to this day.

4. Discussion

Going through the emotional equivalents of the three interaction stages:

(1) Connection;
(2) Identification;
(3) Separation.

Above all, focusing on connection rather than separation reduces parental anxiety and allows the therapist to continue working on delegating independence to adolescents, which precedes the formation of responsibility as a key personality trait.

In many of the studied cases, after conducting a primary psychotherapeutic interview, the presence of autoaggressive manifestations was established, and the most common form of autoaggression is the depressive state (Dunbar, 1936).
5. Conclusion

Regardless of the type of symptom and its magnitude, the relief of accumulated stress occurs by going through 4 basic steps to peace of mind, the key of which is to establish the origin of anger. The subsequent process is individual for each client, but the work of the therapist is more focused and aimed at eliminating NOT the symptom, but the cause of its appearance, which is the main task of the psychotherapeutic process.

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References


