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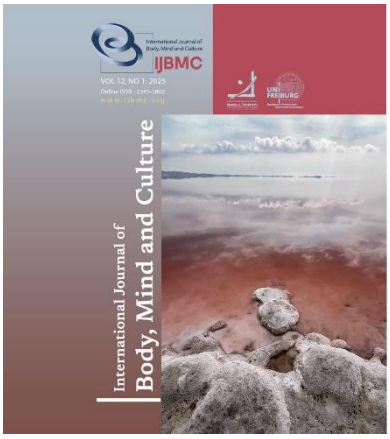
Body Psychotherapy in Somatic Symptom Disorder

Ulrich. Sollmann[1*]

1 Psychotherapist, Boochum, Germany.
Corresponding author email address: sollmann@sollmann-online.de



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ABSTRACT

Somatic symptom disorder (SSD) represent a complex interplay between physical symptoms and psychological factors, often leaving patients in a cycle of chronic discomfort. Traditional approaches, such as Cognitive Behavioral Therapy (CBT), address these conditions by reframing catastrophic thought patterns. However, a significant proportion of SSD patients have undiagnosed mental health disorders, necessitating a broader therapeutic framework. Integrative Body Psychotherapy (BPT) emerges as a holistic intervention, emphasizing body awareness, emotional processing, and self-expression. By merging verbal and non-verbal techniques, BPT fosters a deeper connection between the body and psyche, offering an innovative pathway for alleviating symptoms and enhancing resilience. This editorial explores the theoretical underpinnings and clinical applications of BPT, highlighting its potential in group therapy settings, cultural considerations, and the critical role of the "Now-Moment." The article underscores the importance of a patient-centered approach that respects the somatic experience while integrating cognitive, emotional, and social dimensions to achieve comprehensive care in SSD.

Keywords: Somatic symptom disorder, Body Psychotherapy, Emotional Processing, Mind-Body Integration, Chronic Pain Management.

A thirty-two-year old woman involved in a special training-program for physicians complained about regularly occurring, heavy headaches. She has suffered from these headaches for many years. Her headaches were diagnosed as a Somatic symptom disorder (SSD). She tried various medications, sports and relaxation exercises. Via her own study and personal experience as a physician, she knew that it would be difficult for her to find proper treatment, nor could she reach a state of deep relaxation and well-being in her life. Nothing helped nor stopped the chronification of her pain.

Many psychological and psychiatric theories explain SSD (Somatic symptom disorder) as highly connected with negative, distorted and catastrophic thoughts and reaction of triggering critical live-events. Currently, cognitive behavioural therapy (CBT) is regarded as the most appropriate treatment for SSD (Schröder, 2012). Clients are helped to experience and to regard their own symptoms as not so catastrophic-like as they experience them. To feel relaxation and less catastrophic thinking would, per CBT concepts, reduce the “worsening” of symptoms.

There’s another approach and field of scientific research that states that a high proportion of SSD

patients have undiagnosed and therefore untreated mental disorders (Fritzsche, 2020). A much broader concept of treatment and multi-modal therapy is required for the somatic emotional and functional aspects of SSD.

Body Psychotherapy and SSD

Body psychotherapy (BPT) offers a needed integrated treatment intervention.

Considering that an essential element of psychosomatic disease consists in not being able to perceive and accept one's own emotionality and its underlying psychodynamics connected with the physical symptoms, the popularity of books about BPT might be understood as an indication that primarily the public of clients, the virtual psychosomatic patient so to speak, has made a first (self) therapeutic step.

The considerable interest in the books about BA from the seventies onward can also be understood as an expression of half-conscious awareness about health and personal well-being. People want to learn how to better understand themselves and live their lives and their relation with their body. This interest is responded to by the resource-oriented, creative concepts of BPT: improvement of one's grounding, body awareness, self-experience, emotional presence and self-expression, sense of coherence and finding of one's identity in the sense of a true authentic (body) self as well as training of resiliency and stress resistance.

BPT involves many of these needed criteria to work on the different levels of personality: body-level, level of emotions, cognitive level and functional level. "The body-psychotherapy approach combines verbal with non-verbal strategies with the focus towards emotional processing/expressiveness, movement, behaviour and body/self-perception; it's regarded as advantageous for patients with SSD since the bodily complaints remain the focus of therapy. The therapy is not aiming to 'eradicate' symptoms but to work with and through the body in respect of mental distress, associated with the symptoms. The interventions do not directly address psychological processes associated with bodily experiences, aiming at a subtler integration of the somatic and psychological aspects" (Röhricht & Elanjithara, 2014).

Many clients who suffer from unexplained physical symptoms cling to the believe that their symptoms have an underlying physical cause. Many of the patients are still convinced of a medical or somatic explanation for their symptoms though other approaches of understanding the symptoms are explained by the doctors. Patients with SSD believe that their body is dysfunctional, not that there is an associated personal feeling. They are convinced that there is a somatic/physical illness underlying their problems and pain. It is necessary in BPT, as well as in other therapeutic approaches dealing with SSD, to accept this and not to address the experience and the problems too fast, too early, or on the emotional and psychological level. The therapist points out to the patient that he "believes" this and he also believes that the suffering, the pain, and the herewith connected problems are real. Insofar as the psychotherapist does not oppose the patient's explanations, he tries to enrich the experience and facilitate a new thinking model for the patient via new bodily, emotionally and interactional experiences. Body psychotherapy with SSD can be compared to the navigation in difficult, new, and unexpected fields of experience. There is some evidence supporting the notion that BPT can be helpful for patients with SSD (Röhricht, 2009).

Following this therapeutic strategy, especially in the beginning of the treatment, clients are open for support and improvement of daily functioning, stress-reduction and becoming familiar with the experience that others also suffer from such symptoms. Following this therapeutic strategy, especially in the beginning of the treatment, clients are open for this kind of support if the doctor takes the patient's personal body-experience seriously. The more the client feels respected in this way, the more he can talk about his personal experience and feelings that are connected with the symptoms and with the way he sees himself in his daily functioning. If this can be discussed in a group-therapy-setting, patients also can become familiar with the experience that others also suffer from such symptoms.

Body Psychotherapy as Group Psychotherapy

Recent evidence has supported body-psychotherapy as an appropriate approach when working with patients experiencing unexplained medical symptoms and SSD. “The BPT-model offers a fundamentally different approach connecting cognitive and emotional levels with bodily states through enactment and expressive movement exercises” (Röhricht & Elanjithara, 2014).

Röhricht’s (2011) manual for group-body-psychotherapy shows exemplarily a concept of practical body-work and understanding body-awareness and body-experience aiming at a deeper, more personal level self-awareness, self-expression, behaviour modification and sensing as well as the relevance of emotional and psychological problem-solving.

It is thus considered important, especially in the beginning of therapy, to stay on the body-level. There is no explicit relating to potentially occurring states of awareness, inner psychic conflicts, hyper-arousal, negative cognitions, and so on. Rather, one works with the here and now level of body-awareness and body-experience and on communicating these experiences.

“The chosen intervention strategy must match with both: The client’s expectations and the phenomenology of the symptoms” (mostly bodily sensations) (Röhricht & Papadopoulos, 2011).

Thus, body-psychotherapy with somatoform disorder symptoms may result in:

- a conscious new awareness and experience of one’s own body
- a connected, trustful relationship with the therapist
- a guided, well-contained experience of ambivalence as a way to give up a little control in order to experience an impulse of self-regulation in the body and own`s acting, reacting
- specific feedback, if experienced in a group context, by group members in the role of observer
- a complex variety of other approaches.

Reference to the social and / or cultural context

I met the client in a workshop with other physicians, psychologists, counsellors and social workers in Shanghai at Fudan University. She talked about her pain and the severe headache as well as about her specific life situation, which was characterized by intensively experienced stress especially since she finished her degree as a specialised physician. There was also severe stress in her clinic team related to seeing too many patients by herself and being consciously engaged in adapting concepts of Western medicine.

The sinologist Roetz (2006) sums it up not only for China: "It is the unity of integration and integrity that constitutes genuine Confucian ethics."

What does this mean for psychotherapy? What does this mean for the integration of psychotherapeutic thought models and practices with regard to different social and cultural contexts? And how can psychotherapy/psychosomatics understood in this way use the relationship to the body not only as a reflective trick, but also integrate it as an essential element in the interplay of body, psyche, behaviour and culture, so that precisely this element enriches the transcultural discussion about psychotherapy/psychosomatics (Roetz, 2006).

It is ethically, communicatively and professionally gratifying that the IJMBC is actively, concretely and theoretically involved in such a basic understanding of psychotherapy.

Psychotherapy and psychosomatics are proud of a decades- and centuries-long tradition, which, from a global and historical perspective, has led to very different ideas and the associated concrete practice in different cultures. There are now numerous scientific and praxeological efforts to bring the different ideas into a discourse that should enable a fruitful integration.

While talking about and explaining her pain and life situation, the client seemed to be quite balanced though she categorised her pain on a scale between 0 and 100 at approximately 85-90. This was astonishing to me as I realized her gradually changing facial expression while she talked about her pain and life-situation. I did not yet refer to the emotional or psychological part of the complaints. I asked her about how she could handle the pain and integrate such a severe life-situation into her professionally well-done and demanding job. She responded spontaneously to the stress of the present situation following, unconsciously, her habit not to show to someone that she had a headache, that she had chronic pain, and how it felt to have such a severe headache. Instead of this she was silent and smiled a little, unconsciously expressing a message to me that I interpreted as "it`s your turn."

Reference to the neuro sciences

Nature and culture, heritage and environment, body and mind, what is the human being? Neuroscientists explain our perception, our memory, our attention and even our consciousness and ourselves with the neuroyal mechanisms of the brain. What does this mean for our image of humanity, for our conception of ourselves as human beings? Is our brain nothing more than a mere pile of nerve cells?

In philosophy, the question of whether humans are more than mere biological nature has been discussed repeatedly for almost 150 years. Today, brain research claims to have found the answers. But does neuroscience really have the primacy in explaining what it means to be human? What role does the environment play? There is no doubt that our early experiences and the environment in which we grew up shape us throughout our lives. The environment is firmly anchored in our consciousness, so to speak.

Interestingly, neuroscience has also recently turned its attention to culture. The new discipline of "cultural neuroscience" is building bridges between neurobiology and cognitive psychology on the one hand and anthropology and cultural studies on the other (Northoff, 2014). What does this mean for the significance of the body in psychotherapy/psychosomatics? The body is more than classical (Western?) physiology would have us believe. The body is always an experienceable body, an experienced body and a perceived body in a space of shared experience, together with a counterpart and in interaction with others in a specific society/culture.

And yet, at the same moment, in the here and now of the situation in the group, she, by talking again, addressed the deep bodily suffering that was connected with her headache. But, just for a slight moment, (as later observed this is part of her pattern of behaviour and can be experienced when she is under stress), I had the impression that the rigidity of her habit not to open up emotionally and nonverbally towards somebody else would resemble the intensity of her pain and suffering. Could it be, I asked myself, that this compensation would make it difficult for her to feel herself as a "victim of the pain", as emotionally and psychologically deeply touched and strained by the chronification? Was she feeling pain, sadness, desperation or even anger towards the ongoing torture and the self-torture and not opening emotionally to somebody else?

A detailed discussion of the importance of the body in different cultures would go too far at this point. If we look at developments in this area in the Western hemisphere, there has been a great deal of effort for some time now to overcome the dualism between body and soul, body and mind, or to rethink their interaction. Surprisingly, and I say this as a body psychotherapist, many colleagues find it difficult to keep the body (also) in view as an experienced and tangible body and to honour it accordingly in theory and practice.

The relevance of the "Now-Moment"

The psychoanalyst Daniel N. Stern (Stern, 2004) attempts to scientifically substantiate the fundamental importance of the reference to the experienced/experienced body, based in particular on the results of his empirical studies. His explanations refer, for example, to the significance of the "present moment" (the now moment). Stern says: "This kind of moment is what the Boston Change Process Study Group calls a 'now moment'. (...). It is a moment of Kairos when, all at once, many things come together and come to crisis in the therapeutic relationship. In that short time window if you act, you can change the destiny of what will happen. And if you don't act, the destiny will be changed anyway because you didn't act. Kairos is the 'moment of opportunity', like a 'moment of truth' or a 'decisive moment'. Such 'now moments' cause much anxiety in the therapist, who is not sure what to do, and there is not an appropriate technical fall back position that is acceptable, clinically and perhaps morally. Therapist and patient both sense that something momentous is happening, that the ongoing therapeutic relationship has been threatened and put at risk. Also hanging in the air is the therapeutic framework or at least the traditional, personal way the patient and therapist have been working together, up until now. Such moments demand an alteration in the intersubjective field between the two. It is not important whether one wants to put this in terms of the transference-countertransference momentary stance. It is a two-person event involving a potentially perturbing change in the intersubjective field of the total relationship, transferential and real."

Of course, I didn't talk to her yet about feelings and psychological aspects because she, by herself, had not

addressed this issue or perspective of pain symptoms up to that moment. She described the beginning and occurrence of the pain related to the growing intensity of stress in her life and work. Especially then, as she pointed out, she felt a spontaneous impulse, or rigid self-demand, not to give in to this pain but to concentrate more intensely on what she had to do and on her duty to fulfil the needs of others, of her patients, of the clinic and the needs of the next examination, as well as the needs of her super ego. And yet, the symptoms, or perhaps it is better to say that her symptomatic reactions to the unconscious experience of more stress were "worsening" the symptoms and her experience of stress. But she remained silent. No complaints but more rigidity in her posture, her back, and the fixed look at me as the therapist.

One of Stern's differences as a psychoanalyst is that he does not primarily assume unconscious repressed knowledge or associated defence mechanisms or resistances in relation to the experience and experiencing of the body. Instead, he is of the opinion that the early experience of an infant/toddler is not psychodynamically repressed, but is located in the space of non-conscious, non-verbal existence. He therefore advocates transferring this non-conscious knowledge into consciousness and promoting and supporting behaviour that is linked to and enriched by this, so that it can also be perceived and jointly created by a counterpart.

While talking in detail about her specific situation, she suddenly was touching her upper chest with her right hand to point out that she felt a loss of energy there while being in such a stressful situation. At the same time, she straightened a little bit more yet stayed in this rigid posture. She must have felt very uncomfortable, I guessed in my counter-transference, but she did not express this at all verbally. Her face still showed a slight expression of being touched and a little sad. That was all. Again, I did not refer to her facial expression, her emotionality or the psychological experience/psychological background of the pain because she seemed not yet able to emotionally face this. Especially not yet ready to face this or even talk about it in public, in the group. Though I myself, in the counter-transference, felt the rising and growing pain as well as the rigidity not being able to move. I imagined how it would be for her to experience this so often in her life without being able to talk about her life situation. For a moment, I myself empathised with her pain, her loneliness, and I got a slight impression of the intensity of her unexpressed feeling.

In therapeutic terms, engaging with the experienced, tangible body in a lived relationship corresponds to a "discovery", a "shared adventure" between therapist and patient. Stern summarises his basic understanding with an example: "Everyone knows how to kiss and what it feels like to be kissed. If you wanted to describe, explain and understand the process of kissing, you would, for example, refer to the activity of certain muscles in the mouth and so on. The further description would take a certain amount of time. But you would not be able to grasp the essence of kissing.

"The Now-Moment" is originally a physical-experiential event in a (non-)verbal exchange with a counterpart.

Psychotherapy and psychosomatics endeavour to alleviate or heal patients' complaints and suffering. According to Stern (Stern, 2004, 2007), such a process of change always takes place here and now. It is therefore always about taking into account psychodynamics and biographical experience, the relationship between therapist and patient and the requirements that arise from the patient's everyday behaviour.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

None.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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Authors' Contributions

All authors equally contributed to this study.

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