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# **Illness as Strategy and Communication**

David Zigmond

In spite of the vast bulk of literature deriving from psychoanalysis and applicable to medicine, the predominant orientation in the training and practice of doctors remains entrenched in concepts of illness which are mechanistic and unconnected with the patient's emotional and relationship matrix. Perhaps the increasing precision and sophistication of our technology has made other dimensions of illness seem less important in assessment and management.

Modern techniques of diagnosis and therapy are now complex, powerful and, at times, dangerous. Because of these developments, it is hardly surprising that the contemporary doctor may see himself as some kind of biological engineer or technician, whose job it is to rectify faults in the human machine. However, there are emotional factors which are also operative in maintaining this kind of technocracy and alienation between patient and doctor. We can think of these as 'defences' whose function is to protect both parties against distressing and threatening feelings, and also conserve the doctor's position of executive power. I have explored some of these factors in an earlier paper (Zigmond 1977) but here I want to elaborate further the role of illness in meeting the emotional needs of patients. Without this approach, I believe, diagnosis and therapy are often liable to be less effective. Four cases are described later to illustrate this.

### **Illness as Strategy**

Illness is usually conceived and experienced as a malevolent intrusion by an alien force, which has no connection with the self and its relationship with others.

Whatever our knowledge of the mechanics, the illness is felt and thought of as something apart, that strikes us 'out of the blue'. Because of this split we feel that we are at the mercy of the disease process, which seems to have an autonomous, even magical, existence. In the face of illness, therefore, we are all liable to feel helpless and dependent, either on the disease process or on any person who may alleviate it. In psychoanalytic jargon, disease may be said to be 'ego-dystonic', i.e. separate from the familiar complex of volition and experience that we conceive of as 'the self'. Such infirmity, therefore, may compromise our usual traits of independence and individual effectiveness. When ill, we often find ourselves incapable of making

decisions or performing the necessary tasks to realize them. A state of regression is engendered, where autonomy is necessarily abdicated. If a man in his 40s, for example, is admitted to a coronary care unit, it is likely that he will be necessarily regressed to the early infant stage. He will be put to bed, washed, and evacuate himself into a bottle or bedpan. Such dramatic and coerced regression may be difficult, but any resistance on his part is likely to have him branded as 'uncooperative'.

Alternatively, however, illness may have its uses. There is a childlike and dependent part in us all, whatever our age or maturity. From the infants we all were, there remains our archaic and relentless drive for recognition, attention and care from those around us. Equally, we may at times feel immense rage and destructiveness towards those who are closest, just as the infant does rather more overtly. Because of societal taboos, such intense dependence or rage is clearly discouraged. Illness, however, is a state where the individual is not thought to be responsible for himself, and thus offers a less stigmatizing and more conventionally acceptable means of regressing into this child-system. Under the cloak of illness we may become helpless, ask others to look after us, act out and abdicate our usual identity-structure. Behaviour which in other circumstances would be criticized or even punished, can be connived at, and often colluded with.

### **Illness as Communication**

It has already been indicated in which way illness may serve as a conventionally acceptable route to regression that might otherwise be considered dys-social or antisocial. This does not mean, however, that illness communicates only archaic and primitive messages. Very commonly an individual has developed his own specific taboos with particular kinds of feelings. Frequently this is because his parents indicated to him that these feelings would be ignored, belittled or even punished. Such moulding of emotional responses occurs via parental influence in a child's formative years. Explicit pressures such as punishment or mockery are clear, but covert pressures such as a hostile tone of voice or parental indifference are commoner, though sometimes equally damaging. The feelings that are forbidden

may range from fear to assertion, from sadness to anger, depending on the parents' area of difficulty. Later on in life this person will be unable to express this particular feeling with direct words and gestures. Instead he will resort to oblique expressions via somatic language which, in his developmental frame of reference, provides immunity from the hurt he received when he was young. In this way psychosomatic illness may be viewed as having its roots in a habitual and compulsive form of body language.

### **Case No. 1: A Little Boy Escapes Bellyaching**

*Stephen, aged seven, is generally a healthy boy who has a good communication with his humorous and intelligent mother. His parents separated when he was an infant. Mother has recently remarried. Stephen is tentatively fond of her new husband but feels insecure with him. In addition, Stephen's real father has fallen into debt and depression and has been unable to pay the usual maintenance, creating an atmosphere of tension and split loyalties for Stephen, who is fond of his father, and has regular contact with him. Because of father's difficulties, he had to defer his weekend visit. The following dialogue then ensued.*

*Stephen: (plaintively) 'Mum, I feel sick and I've got a tummy ache.'*

*Mother: (intuitively, noting his empty dinner plate) 'I am sorry Stephen, it's horrible isn't it? . . . I think you're sad and disappointed that daddy's not happy and he can't come today. But it doesn't mean he doesn't love you... I think your tummy ache is saying that you're a bit angry and sad.'* Stephen then goes to his mother, sits on her lap, has a cuddle and forgets his abdominal discomfort.

*Mother here did not discount Stephen's tummy ache, but more importantly she recognized, validated and accepted his sadness, anger and confusion. Contrast this with a possible and likely alternative:*

*Stephen: 'Mum, I feel sick and I've got a tummy ache.'*

*Mother: 'Oh dear, I do hope it's nothing bad . . . you must go to bed, and I'll call the doctor straight away.'*

Here the long-term and short-term outcomes are likely to be quite different. Mother only takes Stephen's stomach ache seriously because she herself cannot cope with unhappy and distressed feelings. Her implicit message to Stephen is, 'I don't mind you having stomach ache, but don't show me your unhappiness, because I don't know how to deal with it'. Stephen now learns that overt communication of distress, anger and sadness cannot be displayed; he must settle for tummy ache instead, if he is to evoke mother's protection and concern. As an adult he may well be getting antacids from his general practitioner every time his dyspepsia indicates sadness and frustration that he feels inwardly compelled to bear alone. In this latter situation, the alert and empathetic general practitioner will be able to verbalize and accept the patient's distress and frustrations, thereby rendering them more tolerable to the patient himself. The doctor who is able to recognize, validate and hold a patient's unhappiness, performs much the same function as a parent with a child who is afraid of being overwhelmed by the intensity of his feelings. Once confirmed and shared, some resolution or subsidence of emotional problems may be possible. This is a cornerstone of psychotherapy at every level of practice.

## **Case No. 2: Illness as Rebellion in an Over-ordered Family**

*Miss VH is 23 years of age. Since the age of 16 she has suffered from well-documented episodes of mania. All but her last hospitalization were to an organically orientated psychiatric unit, where a wide span of major tranquillizers and Lithium was tried, which may have quelled the acute crises, but seemed to have little prophylactic effect on her disability.*

Her last admission was to a less organically orientated unit, but followed the same cacophonous pattern. On arrival she showed clinical signs of mania in her psychomotor acceleration, distractibility, emotional liability, prickliness, grandiose and discursive thinking, and so forth. However, the doctor sensed her underlying sadness and despair. He offered her his observation saying, 'It seems to me that

underneath all this you're feeling really miserable and helpless'. She stayed silent for some time and her mania seemed to evaporate giving way to a rather sad and confused child. 'Yes', she replied, 'nobody ever listens to me at home, especially my father, so I get angry and they say, "Oh, she's getting ill again, we'd better call the doctor". And he's always on their side. He doesn't listen either, so I have to come into hospital again.' By inference it seemed that VH came from a household where anger and rebellion could not be expressed directly, only through illness – in this case mania. It emerged that VH is an only child, from a stable, professional and rather joyless marriage. Her father is a rigid, authoritarian, ex-military man whose need for order and obedience seemed indefatigable. Mother has learned to adapt through subdued compliance and stamina, but VH never managed this so successfully. Father's moralism and strictures with VH's social life indicated difficulties with his own sexual feelings, and possibly some incestuous impulses towards VH

It was only through acknowledging her very real anger, and frustration with her coerced dependence, that she was able to organize her emotional resources to deal with the problem realistically. In spite of her fear and pain she has now left home, is off her drugs and is forging her own identity slowly but surely. These substantial gains were demanding and difficult: she made good use of skilled professional guidance. Her manic 'illness' symbolized her battle for autonomy and has not returned.

### **Case No. 3: A Desperate Struggle for Recognition in Infancy**

*Baby Kevin F. was aged five months on admission. His birth and first three months had been physically uneventful. For two months, however, he had been restless and posseted all his feeds, so that he had lost weight dramatically. On admission he was evidently very ill; his weight was on the third percentile, he was extremely frail and dehydrated, as attested by his sunken fontanelle, dry tongue and raised blood urea. His history was against congenital pyloric stenosis, and barium studies failed to show a hiatus hernia. In physical terms his diagnosis was one of rumination syndrome – he had no physical lesion, but was bringing back his food for self-gratification and to evoke contact with others.*

The family and emotional diagnosis was more difficult and complex. His parents were an intelligent and ambitious couple, and this was their first child. Mother was an insecure and prickly woman, who escaped the conflictual relationship with her short-tempered father by getting married to a man who was very much like him. Mr and Mrs F. thus lived in a state of competitive discord, and Mrs F. harbours extensive grievances against men because she feels they will control her and usurp her independence. She had been doing well in her career as a teacher, and became pregnant ambivalently with pressure from her husband. Because of her feelings about the men in her life, she secretly hoped for a baby girl with whom she could develop an alliance of women.

With the birth of Kevin she felt bitterly disappointed, and found herself unable to give him the maternal and nurturing responses that were necessary. Kevin was fed, bathed and bedded efficiently, but was never played with or enjoyed. He would sit in this pristine cot wanting to explore or be loved, but mother sat silently and sullenly doing *The Times* crossword puzzle. Kevin's progress in hospital was dramatic. He was played with, chatted to and smiled at by the nurses, and his feeding difficulties soon settled, with the attendant improvement in weight. Mrs F. recognized her lack of nurturing, where it came from, and how it led to Kevin's severe illness. Fortunately, Mr and Mrs F. were able to embark on, and co-operate with, a mixture of individual and marital therapy, which brought about a greater fulfilment in their marriage, and a disappearance of Kevin's desperate strategies to be loved and related to.

#### **Case No. 4: Illness as an Escape Mechanism**

*Mr G. K. is aged 53 years. He had been physically healthy all his life until a number of apparently physical crises were brought to the attention of his general practitioner, and then the medical and casualty departments of the local hospital. Over several months he had a number of alarming attacks, consisting of tightness in the chest, a feeling of impending suffocation, paraesthesiae in the arms and hands and prostrating weakness and dizziness. Suspected cardiac and respiratory disease was never confirmed, but he continued to be*

*subject to these crises, with the consequent hospitalizations and investigations. The only positive physical finding was a persistent mild idiopathic hypertension (BP 170/110). Eventually the recognition of these episodes as panic attacks led to an exploration of his underlying problems.*

Mr G. K. is a Greek Cypriot but has spent most of his adult life in this country, has married an English woman and now has three teenage children. Early on in his life Mr G. K. decided that he must be strong, ignore his own feelings but look after other people, whom he needed to perceive as less strong than himself. He learned this life-role as a child because of his parents' own marital difficulties. Father was a large and unhappy man whose resentment with his lot was largely projected onto his wife and children via displays and acts of violence. These were exacerbated by his drinking and gambling, which gave mother an excuse to persecute him, thereby perpetuating the vicious circle. Although he might physically assault mother, he would stop short of this with his children. Mr G. K. learned, as a small boy, that he could rescue his mother by interposing himself between his parents. However, to do this he had to be able to deny his own fear of the situation. As a child of six years he learned that his mother's survival depended on his rescuing her with his bravado and fearlessness. This role was pursued relentlessly despite the circumstantial changes in his life. Father died and he came to England with his mother, where he soon met his future wife. Although his new family was under no real duress, he still felt the compulsion to be the never-failing rescuer and provider. He was a warm and caring man, but could only show this by working 'for the family' to the extremes of his physical endurance, and by taking on a firm patriarchal role in the belief that his family could never function autonomously without him. This hero at war was not an easy man to love at home; he and his wife insidiously became emotionally and sexually estranged.

It was the Turkish invasion of Cyprus that brought forward the collapse of this man's outdated and cumbersome defences. His home town was destroyed, and with it many friends and relatives who together formed so much of his emotional roots. His grief and hurt were enormous, but because of his lifelong bravado and denial of weakness or feeling he was unable to acknowledge these to himself, even less be

comforted by others. In an effort to escape his feelings of impotence and loss, he worked at the expense of even more time and energy. Eventually this defence also became inadequate and led to his panic attacks. Although his taboo on verbal communication of distress made this initially impossible, the message in his panic attacks was quite clear. His pent-up feelings of loss, despair, fear and powerlessness were all evident in his cries, his choking and trembling. Here was powerful somatic communication, while his tongue had not yet permission to speak. Psychotherapy with this man has been brief and gratifying. Encouraging him to acknowledge, re-own and share his vulnerabilities and feelings has abolished his unwitting strategy of illness, and brought about much emotional growth in his family and marital life.

Medically it is noteworthy that he has reverted to being normotensive, and is now maintaining this without his hypotensive drugs. Such exploration and therapy of his somatic communications has hopefully freed him of the need to be ill in order to express and work through his distress. The absence of such intervention could have resulted in a much more real and physically damaging cardiovascular catastrophe.

## **Conclusion**

We are all an amalgam of what we consider to be creditable and discreditable qualities – what we wish to be, and what we fear we may be. Generally we are conditioned to thinking that 'good' qualities are those such as strength, autonomy, generosity and courage. However, there is a child-system of percepts and feelings in everyone which confronts us with our intense and primitive feelings of rage, destructiveness, infantile passivity and the wish to be taken care of. This infant part of ourselves remains active, but discouraged from expression by societal taboos. Some families, also, have more particular taboos with other feelings, such as fear and sadness. Because all these feelings are powerful but not allowed direct expression, they must be split off and expressed, covertly, leaving the rest of the apparent personality intact. Illnesses of many kinds offer such a system of strategy and communication; this not only applies to psychiatric and hysterical syndromes, but also to very tangible organic reactions such as duodenal ulceration and asthma.

Although alternative skills are required to understand the language of illness, the results are often gratifying, and at times may even be lifesaving.

## **Reference**

Zigmond, D., *Update*, 1977, 15, 159.

## **Bibliographical Note**

Nothing said about the relationship aspects of medicine would be complete without reference to the contribution of Michael Balint. His book *The Doctor, his Patient and the Illness* (Pitman Medical 1968) is now an established classic. I have also found the concepts of Transactional Analysis invaluable in formulating the developmental and transactional basis of illness as a form of communication. The following books provide an excellent introduction to this system of psychology:

Berne, E., *Games People Play*, Penguin, Harmondsworth, Middx, 1967

Berne, E., *What do You Say After You Say Hello*, Corgi Books, London, 1975

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