On Questions of Psychosomatics

Author: Titusz Tarnai

1

Approach to psychosomatics.

To approach the discipline of psychosomatics, it is best to begin with contemporary scientific definitions, which have been circulating throughout the last forty years. *Psychosomatic medicine thus is defined as a scientific discipline that investigates correlations between biological, psychological and social determinants of illness and health.* (Lipowski, 1977) The field is described as a field of scientific medicine, where a certain openness as to the aetiology of diseases is not only the core ambition, but also the area of research. Departing from the singular biological model, *the discipline is to take a specific attitude of a care-giver in the health system that shows a holistic understanding and a holistic practice in the field of medicine.* (Uexküll, 1997) Here a fundamentally postmodern thought, that of complexity of influences, enters the practice of medicine. Environmental, social, psychological factors in the development of infirmities become the focus of investigation. The search for overlooked causalities beyond a deterministic view, a view which has come to practice due to the division of labour and specialisation in the field of medicine, is taken on. Yet, as the mechanistic organisation of causalities, which is now to be transcended, has taken hold on our world view in the wake of cultural development driven by technological advance and rational schools of thought, the field of psychosomatic investigation is found to be rooted in ancient science. At the time of the Greek cosmologists, the rules and laws governing the universe and health were not so strongly delimited, the uncertainties at the time have allowed for models to develop, in which the relationship between matter and phenomena were more loosely organised. Hippocrates, as an example, understood epilepsy to have natural material causes, deemed it ‘sacred’. Even though these models have been devised in the absence of a technical clinical environment, they drew upon close empirical observation and were articulated in the framework of a naturalistic metaphorical regime, which in modern times has been rather marginalised and thus misunderstood. The medical schools in the age of Enlightenment, where observation of visible phenomena, subsequent categorisation and the search for clearly demonstrate able rules following, adhering to the same rigour as put forth in physics by Newton and astronomy by Kepler, to name a few, combined with the foregrounding of the newly available perspective on the human body by anatomy, thus were formed as bastions of a scientific discipline which relied on experiment and reasoning. There were few voices, who dared to call in for soft and diffuse factors, raising questions towards the role of affect and bodily homeostasis: *What indeed is more serving of attention, than the fact that in almost every affection, appetite, hope or fear, our body suffers, the countenance changes, and the blood appears to course hither and thither?* (Harvey, 1649) Thus it was not until the psychoanalytic model has entered the stage of the medical discourse that a first modern model on the interaction of soma and psyche was constructed at the turn of the 20th century. The investigation of hysteric symptoms by Sigmund Freud led to the discovery of routes linking the psyche to the soma. The defence mechanism of conversion, which began to explain processes of displacing unbearable mental pain onto the realm of the organic was met with fierce criticism by the medical society. Yet, Freud has in his publications successfully demonstrated the validity of his model by publishing

successful treatment of bodily symptoms by the use of the analytic method. In his topographic model, which structures mental functioning according to conscious and unconscious processes, the domain of the dynamic unconscious, where primary processes continue to prevail, is identified to have the power to develop organic reactions to psychic conflicts. Thus the cure is to haul those repressed conflicts, which arose from the strong instinctual wishes repudiated by ego defence mechanism, the repudiation having taken place unconsciously, back into consciousness. Disciples of Freud, such as Groddeck have continued the work on the investigation of interaction of soma and psyche. Notably Franz Alexander compiled a list of organic diseases with significant prevalence which could be traced back to psychological conflicts and trauma. The concept of autoplastic adaptation, whereby the subject intends to change himself, the internal environment, as opposed to the alloplastic adaptation, whereby the subject's effort are directed towards changing the external environment, when facing a stressful situation, further allows for a new perspective in the cause of illnesses.

Categorisation of psychosomatics.

In this section the four major models of psychosomatics will receive attention. 1. The conflict model following the classical analytic model, 2. the deficiency model as presented in the wake of attachment theory, 3. the learn theoretical model resulting from the positivistic behavioural theory championed by Pawlow and Bandura, and 4. the stress model, are retraced.

As briefly mentioned above, Freud in his work has argued that the cause of bodily symptoms in the case of hysteria have clear roots in psychic suffering, the symptoms being indexical of repressed conflicts. In his case studies he has demonstrated that each symptom is an expression of a conflict and thus has a meaning. In the case of obsessional neurosis for example the obsessive behaviour is a translation of the contradictory forces of primary wish, mainly of sexual origin, which then meets a strong resistance by the later formed super ego, as the wish stands in contrast to accepted cultural norms. As a consequence, the psyche, according to its maturity, has access to a variety of defence mechanisms, the function of which is to handle the arising stress and anxiety and to direct those into bearable channels. Defence mechanisms of a weak ego are mainly manic and pathological, denial, conversion, omnipotence, whereas the mature ego is defined by having achieved the development of more mature mechanisms such as sublimation or altruism. The theory is based on a model of tension, which needs to find an outlet in one way or another. Symptom formation can take routes via psychological means, such as obsessive behaviour, or can find relief through the body as in the case of hysterical conversion. In any case, following the model of erogenous zones, the body remains in a close relation to psychical functioning, the body remains to contain a map of psychic impulses. Drive theory is located on the border of soma and psyche. Whereas the body with its erogenous zones is responsible for the source and pressure of the drives, it is in the realm of the psyche that the drives are channeled to aims and objects. In the theory of the transference neuroses Freud emphasises these routes between mind and body, and whereas he initially contrasts to this field of pathology a class of actual neuroses, which are understood to be devoid of analysable meaning, in his later theories he comes to distance himself from this category, approximating a stance that supposedly any bodily symptom has potentially a psychological trigger. Allergies and autoimmune reactions are discussed in the light of the autoplastic model as mirroring psychic reactions to traumatic events. Dyspnoea which reproduces memories of the intense breathing of the father in the course

of the observed primal scene, infantile asthma, caused by a quasi suffocating nursing of the primary caregiver, are few examples where the body comes to reenact events from early developmental impediments.

In contrast to the image of the mind as a loosely associated network of drives and impulses, which at points come to contradict each other, Bowlby capitalises on a single united ego model, to which attributes of strength and weakness are applied. If the infant's ego is strong, it is able to develop compromises actively in the wake of experienced conflicts and thus does not need to resort to bodily outlets. Yet, if the ego is not sufficiently robust, if the gaps are too wide, the ego is easily overwhelmed. Chronic deprivation and sustained traumata impede on the development of the ego, comprise early attacks, to which the infant does not find the means to defend itself, as the source of stress in this case is exactly the place, where the infant would turn to for reinforcement. He thus is left to his own undeveloped devices. The weak ego in conjunction with the vivid and active neural connection to the body result in the displacement of stress through somatisation. A clearly observable psychic deficiency can be found in Alexithymia, which *refers to a specific disturbance in psychic functioning characterised by difficulties in the capacity to verbalise affect and to elaborate fantasies. Although initially described in the context of psychosomatic illness, alexithymic characteristics may be observed in patients with a wide range of medical and psychiatric disorders.* (Taylor, 1984) Here the notable positive correlation of a psychic deficiency with mental and somatic disorders supports the core psychosomatic argument of causation parallels in mind and body, but also illustrates the deficiency model.

The learning theory model of psychosomatics contains the *central assumption that individuals who are at risk are those who fail to unlearn transitory physiological reactions when they are no longer appropriate to the environment or the life situation*. (Levey, 1981) Thus the light under which psychosomatic complications are revisited is that of the formation or retaining of maladaptive responses. Classical conditioning is a theory of learning by forming lasting associations between conditional and unconditional stimuli which influence the resulting behaviour. On the level of reflexes, an organism will form certain expectations from the exposition to conditional stimuli as it has learned to associate it with an upcoming relevant impetus such as food or danger. As it is a model which draws its validity from observations in simplified isolated situations on the level of clear input output scenarios, the idea of a causality is carried over, informing the psychosomatic discourse, to the level of organic responses to certain forms of stress to be understood as failed forms of the conditioning mechanism. In research, prototypes of forms of maladaptations are collected by the use of large scale conditioning studies. Here the findings have discerned correlation between levels of inappropriate responses in a test situation to organic maladjustments. The underlying hypothesis is that individuals who in general have a tendency to diffuse reactions will also likely to develop psychosomatic illnesses due to similar diffuse reflexes on the somatic level. Another important issue which is carried over from the analytic discourse is the phenomenon of secondary gain of illness. Whereas the primary gain signifies the immediate relief of psychic tension through symptom formation, secondary gain accounts for the resistance of a patient to cure, as it has learned to draw benefits from his illness i.e. through social benefits or other gains such as increased attention by family relatives.

Whereas the behaviouristic learning theory model treats the problem from the perspective of the outside observer, refraining to make any assumptions on the internal structure of the biological-cognitive apparatus other than the capacity to adaptive behaviour, the stress model adopts a dynamic system approach in the explanation of disease. Here the metaphor applied is that of a system in equilibrium, which under the constant exposure to destabilising forces reacts in all its capacities to restore homeostasis. Body and mind are a complex system of interwoven regulatory systems, thermostats if you will. Each circuit responds to certain demands or stresses, as for example the deployment of hormones or the regulation of blood pressure in certain situations. Here the model ceases to distinguish between mental and biological. All biological circuits, as being responsive, are presumed to contain a certain level of computational intelligence. Thus in the management of stress the organism needs to manage its own resources, which when stress exceeds the level of the manageable, leads to a breakdown. Outbreak of an illness due to a severed immune system is in its dynamics equivalent to psychic trauma in the face of the breakdown of defence mechanisms due to extreme input. An example for this is the condition of shell shock which was prevalent in the wake of the first world war. But also other malfunctions such as diarrhoea or sleep disturbance in the wake of persistent stress do hint to the disturbance of a general homeostasis as certain subsystems are overly agitated.

2

Chronic Fatigue Syndrome (CFS) / Fibromyalgia Syndrome (FMS)

I have opted to reproduce material introducing the reader to two separate syndromes, which appear to stand in a proximal constellation to each other, in both symptomatology and also epidemiology. Both syndromes have in common a diffuse etiological picture and thus further to both forming a class of residual disease, medical and psychiatric knowledge finds its limits. Estimations and cross-referencing takes the place of clear causalities. Thus as the suffering the patients experience is real but of mysterious origin, the constellation of the two syndromes represent a challenging field of psychosomatic research. The following text passages are excerpted from the American Psychiatric Publishing Textbook of Psychosomatic Medicine and are intended to serve as condensed notes in grasping the clinical picture of CFS and FMS.

> The central feature of CFS is the symptom of severe chronic, disabling fatigue that is typically exacerbated by exertion and unexplained by any other medical condition. The central feature of FMS is widespread pain with localized tenderness that similarly is unexplained by any other diagnosis. Although these syndromes have different historical origins, it is increasingly recognized that they have much in common (Sullivan et al. 2002).
> CFS, FMS, and other symptom-defined somatic syndromes are conditions whose homes in medicine (as functional syndromes) and in psychiatry (as somatoform disorders) are both rather temporary structures located in unfashionable areas of their respective communities.
> The history of CFS and FMS has been notable for its vigorous disputes about whether these disorders are organic or psychogenic (Asbring and Narvanen 2003). The extreme organic position argues that they eventually will be found to be as firmly based in disease pathology as any other medical condition. Attempts to establish a conventional pathology (e.g., inflammation in muscles in

fibromyalgia and chronic infection in CFS) have not yet succeeded, however. An extreme psychogenic view is that these syndromes are pseudo diseases, not rooted in biology but rather representing social constructions based on psychological amplification of normal somatic sensations such as tiredness and pain.

CFS

It has been convincingly argued that CFS is not a new illness. A very similar, if not identical, condition was described as neurasthenia more than 100 years ago and probably much earlier (Wessely 1990). The term chronic fatigue syndrome was coined in 1988 to describe a condition characterized by chronic disabling fatigue, with many other somatic symptoms and strict psychiatric exclusions (Holmes et al. 1988).

Several operational diagnostic criteria for CFS have been published. The most recent criteria were based on an international consensus and were published in 1994.
The clinical presentation of the individuals whose symptoms meet the criteria for CFS is heterogeneous, al- though the core symptoms of fatigue exacerbated by exercise, subjective cognitive impairment, and disrupted and unrefreshing sleep are almost universally described, and some degree of widespread pain is common. Patients often report marked fluctuations in fatigue that occur from week to week and even from day to day. Most patients are not so disabled that they cannot attend an out- patient consultation, although some describe difficulty walking or cannot attend an outpatient consultation with- out the aid of wheelchairs and other appliances. Other patients remain bedridden, unable to visit the clinic, and represent an important and neglected group.

FMS

In 1904, Gowers first coined the term fibrositis to describe a chronic widespread pain thought to be caused by inflammation of muscles. However, as with CFS, specific disease pathology in muscle has not subsequently been confirmed.

A variety of different diagnostic criteria for fibromyalgia have been proposed. The ACR criteria published in 1990 are the most widely accepted (Wolfe et al. 1990). These specify widespread pain of at least 3 months' duration and tenderness at 11 or more of 18 specific sites on the body.

The core features of fibromyalgia are chronic widespread pain and musculoskeletal tenderness (muscle, ligaments, and tendons). Pain occurs typically in all four quadrants of the body and the axial skeleton but also can be regional. Fatigue, sleep disturbance, and subjective cognitive impairment (memory and concentration) are common associations. As with CFS, the report of pain is essentially a subjective phenomenon and may not be reflected in at- tempts to assess physical and mental performance objectively.

Patients have a range of associated disability, although most patients are able to attend outpatient services. The symptoms of FMS overlap considerably with those of other rheumatological conditions. Up to 25% of the patients with systemic inflammatory conditions (such as systemic lupus erythematosus and rheumatoid arthritis) can meet ACR criteria for fibromyalgia in the initial stages, thus creating a diagnostic dilemma for the clinician faced with a patient who has an undifferentiated constellation of chronic musculoskeletal symptoms.

Both CFS and FMS are typically diagnosed when the patient has no evidence of another medical condition. This makes it easy to define the symptoms as unexplained by another condition. However, similar symptoms are often found in patients with other medical diagnoses. Many studies have shown an overlap in the symptoms of patients with a diagnosis of FMS and those with a diagnosis of CFS if these are specifically asked about. Put simply, CFS is fatigue with pain, and FMS is pain with fatigue. A latent class analysis of the symptoms of more than 600 patients failed to identify separate syndromes (Sullivan et al. 2002). Not only are the symptoms similar, but a patient who has received the diagnosis of one of these conditions is also likely to meet the diagnostic criteria for the other.

Effective management of patients with possible CFS or FMS requires that 1) alternative medical and psychiatric diagnoses are considered and 2) the patient receives a comprehensive assessment so that collaborative management may be planned.

CFS symptoms (diagnostic criteria)

Type	Symptom
PSY	Clinically evaluated, medically unexplained fatigue of at least 6 months' duration
PSY	Subjective memory impairment
ORG	Sore throat
ORG	Tender lymph nodes
ORG	Muscle pain
ORG	Joint pain
ORG	Headache
PSY	Unrefreshing sleep
ORG	Postexertional malaise lasting more than 24 hours

MFS symptoms (diagnostic criteria)

Type	Symptom
ORG	History of widespread pain.
ORG	Pain in at least 11 of 18 specified tender point sites.

ORG ….. organic symptom
PSY…… psychological symptom

3

Case Examples

3a

Little girl of three and a half years of age is noted by kindergarden teacher to develop recurrent attacks of dizziness and loss of equilibrium. The girl has no prior medical history, is developing physically and mentally healthy. Some two three months ago, the kindergarden teacher draws the attention of the girl's mother to the disturbance, who then submits the child to medical examinations. From the general practitioner the girl is referred to a NET specialist. Results of the examination do not yield evidence of organic disease. The seizures are recurrent, lasting about a few minutes and are not related to concurrent activity. They are in nature sudden and inconsistent as the seizures come about without any identifiable prefiguration. Whereas the cognitive capabilities of the child are according to her age, she is often found to play by herself, apart from the group. Her play can be described as absent minded and meditative. Her playing is dominated by organising and structuring her environment. Using buckets and boxes, her attention is taken up by a strong urge to recast the contents of these containers in ever new constellations. It appears as if she would be permanently trying to establish a satisfying order which eventually never materialises. When other kids appear to join her she manages to engage them peripherally, yet becomes at times infatuated by interventions of the others in her domain of play. The family context of the girl is as follows. She is raised by a single mother and has a half-brother about ten years her senior. The mother since having given birth is unemployed and on welfare. Her social relations are poor, the woman is withdrawing and often takes a negative stance towards her environment. The relationship between the child and the mother appears warm and secure. As the little girl's father is kept at distance by the repeated attacks and outbursts of the mother, the girl and the mother keep a rather intimate level of relationship. Occasional outbursts of anger and sadness of the mother are explained by the little girl, who believes that the mother is 'sometimes unhappy'. The mother yet has a family history marked by abandonment by the father and drug overdose of her older sister around thirteen years back, at the time she was pregnant with the older brother of the little girl. The adolescent older brother has a diminished drive, a lack of perspective and motivation which slightly exceeds the tolerable levels of mood swings found in adolescents. As his father is absent, he carries a deep melancholia within himself. The father in a comparable manner left the son as the mother seems to have been abandoned by her own father. The boy recently moved to the grandparents as he enrolled in a school in the same town. The apartment of the family, where currently the mother and the little girl are living, is marked by an abundance of objects scattered all over. There is hardly space to navigate. The mother is chronically caught up in organising and rearranging the apartment while failing to reduce the amount of objects which she appears to have developed strong sentimental investment. Additionally, the figuration of the rooms is undergoing a constant tectonic change, whereby all seems to be in a constant flux. One would have the feeling of a dizzying disarray, a loss of orientation would set in. Whereas in the presentation of the case the physical causes of the girl's attacks of dizziness remain unclear, it was my intention to include material from her family background hinting to psychological complications. Treatment recommendation would involve to first rule out all possibilities of an organic cause and then to presume to therapeutic treatment of the child in an analytical setting twice a week, whereas for the mother a combined approach of analytical and behavioural therapy could serve well.

3b

Man of 40 years of age, academic and independent artist, unmarried, in a long term relationship, no children, vegan, presents physical symptoms of arthritis, chronic inflammation and pain in joints. The symptoms are persistent and chronic. The patient has accepted them as a part of his life and identity and frequently resorts to complain about them and use them as device to extort feelings of pity and comfort from his surroundings. He sort of has given up, is embracing his bodily disintegration as he perceives himself as old and thus devoid of opportunities, meaninglessness of life, death looming, color his idiom. He is a single child, brought up by his mother. His father has diseased after a longer struggle of cancer when the man was around six years of age. The man frequently blames the father for opting to give up and to abandon the family. He describes his larger family as cruel giving an outcast position to his mother and himself. The others are perceived as rich and successful, the man has a tendency to idealise and envy certain male characters in his environment. He himself has experienced quite some difficulties in his schooling, which he also attributes to his lower class standing. He was subject to physical and mental abuse in school, had to change change school frequently. As a result he developed bulimia nervosa and reports of a juvenile attempt to end his life in despair. In his early twenties he was hospitalised for suspicion of leukaemia, which he reports to have contracted but managed to overcome. Here he makes clear references to his father, whom he at this point appears to have superseded. He overtly talks about having opted for life, seemingly regaining the will to live. He then attends an art academy and begins jobbing in a shop for cartoon magazines. The refusal to face certain aspects of reality, the refusal to mature and to grow up remains a part of his personality. He pursues his PhD in arts while engaging in an art practice. Here he manages to engage collaborations with peers, out of which he mostly ends up emerging defeated and humiliated. His mother remains to play a central role in his life. The man is currently in a long term monogamous relationship, in the course of which he exhibits a position of emotional dependency. His recent wish to have children are met ostensively by the refusal of his spouse, who is an independent spirited hard working woman, who admits not to rely on the patient in terms of building a family. She is earning the family money, they are living a precarious life. The patients everyday is a struggle to pass through the day. Sleep disturbances and manic episodes are followed by breakdowns, in which the patient also becomes accident prone. To challenges such as having to search for a new apartment, the patient tends to respond by getting injured. His motor skills and coordination are defined by ill controlled motions, by an increased risk of self harm, his body language is that of violent eruptions, which breed discomfort and lack of trust in his surroundings. This stands in line with his narrative, a person who is stripped of opportunities, alongside of a persecutory colouring of the surrounding. His wishes are that of a lot of money, to get rich, to seclude himself in a castle. These phantasies are often repeated and projected onto potential saviour figures in his circle. Due to the long term unemployment, the patient has also given up the search for a structured workplace, clinging on to his artistic practice as a sort of freedom which has to be maintained under all circumstances. Thus the patient is investing a lot of mental energy to keep his ego from disintegrating. He is refusing to enter therapy, his manic reparations of his self image do not admit doubt and insight. In conversations he too is keen to retain the position of superior to the other, his trained intellect being his phallus in the Lacanian sense. The chronic joint pains in hands, translating to the suffering to grab, to get hold of a concrete achievement, the symbolised inability to get a grip on life, could drive the therapeutic investigation.

4

Clinical practice

A list of exploratory questions mapping potential psychosomatic illnesses.

1. Are you currently suffering any physical conditions?
2. Do you have any allergies or similar unwanted responses to things in your environment?
3. Please tell me about medical complications in your life starting in your youth.
4. Tell me something about the medical history in your family.
5. Regarding your birth: what phantasies do you have about the events around your birth?
   How do you imagine your mother, your father in this situation?
6. You have mentioned this or that symptom, which you have for such and such period of time. How do you imagine/perceive does the symptom influence your life? Which are the things you are hindered at by the symptom?
7. What could you say about the origin of the symptom? Have you made attempts to explore and to treat the symptoms by medical doctors? What were their findings? Do you have your own theory?
8. Are you blaming anybody for your condition?
9. Have you been able to observe, at which times the symptoms become acute and prominent?
10. Please try to describe the condition in your own words. What do you think is happening with your body?
11. Which are the thoughts and the feelings that come into your mind when you are thinking about your disease?
12. What do your parents, relatives tell to you when you are talking about it?
13. Do you know of similar conditions in your family?
14. Now this symptom is of course real and tangible, and it seems it has gotten hold of you. What do you fear could happen to you, if the symptom persists for a longer period of time? Which anxieties do you harbour?
15. Could you say that you have said all about your physical condition or are there things which we did not touch upon but you at this point perceive as relevant to share?

5

Personal opinion

I have started to study psychotherapy science, quite late in my life, out of a rising awareness which surfaced in the course of my own analysis, during which I began to witness the disparity between the unconscious and the conscious, between the latent and the manifest. A profound experience, which revealed the power of the mental forces that are hidden from perception, I found myself fooled and tricked by the underlying impulses, which I, as an existential endeavour, have cast into a personal challenge to know more about. Not even I am free of symptoms, I have come to believe, and thus in consequence I began observing the individuals in my own surrounding, focusing on their bodily and mental discourse, which they seem to carry along, to which they make references, in a by the way manner. No man can keep a secret, if the mouth remains silent, one just has to observe the hands, or by that same token the body. This is one of the lessons to be learned from Sigmund Freud, which by extension folds into the field of psychosomatic understanding of bodily symptoms. The cases I have described above are just two of the many instances I have come to observe in my last years, by which it appears that mental suffering does more often than not find an equivalent expression on the body. As I have been framing the material of the course in the beginnings of this essay, the history of medicine, of aetiology of diseases came to paper as a science, where the beginnings in antiquity allowed for holistic hypotheses, which due to the development of a technocratic mode of reason was narrowed down to focus on tangible dimensions. This I experience as a loss in perception. When engaging in the reading of analytic literature, a deep understanding of the interaction of parts of the body, which are connected by the nervous system is again made possible. The retracing of cases of hysteria allows the diligent reader to open up his mind to new and for long time ignored connections between mental and bodily suffering. In this sense, my perception has been readjusted to contain the suspicion that many infirmities just might arise out of mental conflicts, out of impasses of the psychosomatic apparatus to handle impeding experiences. The context of contemporary medicine, the divisions in the field of the medical field, of course are still counteractive to the unbiased exploration of the development of diseases. Many people prefer simple recipes to the facing of the origin of their suffering, which is understandable, if one takes the cause of resistance into considerations. In the end, diseases are the relatively bearable condensations of unbearable psychic pain. In many cases, where patients contract an accident or catch a flu, there seems to be a benefit arising from that, and one must be on the look for those. In my therapeutic practice, I am looking forward to the challenge to transcend this invisible barrier between the medical and the psychotherapeutic, as from my experiences in waiting rooms of general practitioners, one does not escape the suspicion that a majority of patients seeking for help brings a big baggage of psychic complaints. Of course, the investigation in each case has to start with the determination of organic origins, and as a responsible practitioner, one has to begin by giving a right of passage to medical doctors, yet on the other hand, it is the duty of the therapist to raise awareness and disseminate the momentum of constructive doubt towards the origin of physical infirmities, both towards general society as to fellow practicing medical professionals. The literature and the research available is comprehensive and convincing, yet at many instances it is neglected due to the lack of attention or due to the fear of losing control and authority maintained by medically trained professionals.

References

Asbring P., Narvanen A.L. (2003). *Ideal versus reality: physicians' perspectives on patients with chronic fatigue syndrome (CFS) and fibromyalgia*. In Soc Sci Med 57 . (pp. 711–720).

Harvey, W. (1649). (1928). *Exercitatio anatomica de circulatione sanguinis*. Springfield, Il.: Charles C. Thomas Publisher.

Holmes G.P., Kaplan J.E., Gantz N.M., et al. (1988). *Chronic fatigue syndrome: a working case definition.* In Ann Intern Med 108. (pp. 387– 389).

Levey A. B. (1981). *Learning Theory and Psychosomatic Disorder*. In Journal of Psychosomatic Research, Vol. 25, No. 5. (p. 475). London: Pergamon Press Ltd. DOI: http://dx.doi.org/10.1016/0022-3999(81)90074-X

Lipowski, Z. J. (1977). *Psychosomatic medicine in the seventies: An overview.* American Journal of Psychiatry, 134, (pp. 233–244).

Sharpe, M. C., O'Malley, P. G. (2005). *Chronic Fatigue and Fibromyalgia Syndromes*. In Levenson, J. L., Ed. Textbook of Psychosomatic Medicine. Washington, DC: The American Psychiatric Publishing, Inc. (pp. 556 - 589).

Sullivan P.F., Smith W., Buchwald D. (2002). *Latent class analysis of symptoms associated with chronic fatigue syndrome and fibromyalgia.* In Psychol Med 32. (pp. 881–888).

Taylor, G.J. (1984). *Alexithymia: concept, measurement, and implications for treatment*. In American Journal of Psychiatry. 1984 Jun;141(6). (p.725-32).

Uexküll T. von, (1997). *Psychosomatic Medicine.* München: Urban & Schwarzenberg

Wessely S. (1990). *Old wine in new bottles: neurasthenia and M.E.* In Psychol. Med 20. (pp.35–53).

Wolfe F., Smythe H.A., Yunus M.B., et al. (1990). *The American College of Rheumatology 1990 criteria for the classification of fibromyalgia: Report of the Multicenter Criteria Committee.* In Arthritis Rheum 33. (pp.160–172).