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Psychosomatic Risk from the Perspective of Attachment Trauma and Disturbances of Physical Self

Ryzyko psychosomatyczne z perspektywy traumy przywiązania i zaburzeń Ja cielesnego

ABSTRACT

The following paper discusses the etiology of psychosomatic disorders. It proposes and develops a hypothesis that connects psychosomatic risk with traumatic experiences in early childhood, including parental bonding pathology. To validate the hypothesis, the paper stresses the deep resemblance between the consequences of childhood trauma syndrome (DESNOS syndrome) and the long-term results of negative somatic experiences, including the change in functioning on the neurophysiological level (Bowlby's attachment theory, object relation theory, study results for negative impact of somatic experiences, carcinogenesis models). On the other hand, the proposed hypothesis is backed by the current widely accepted role of stress together with adaptive and defensive strategies. They are reflected in the forming of the type A, C, and D behavior patterns in adults and their significance (apart from constitutional weakness) as factors of psychosomatic risk.

Key words: etiology of psychosomatic disorders, psychosomatic risk, traumatic factors, type A, C, D behavior, parental bonding, childhood trauma, body experience, body image.

STRESZCZENIE

Opracowanie podejmuje problematykę etiologii zaburzeń psychosomatycznych. Stawia i rozwija hipotezę wiążącą ryzyko psychosomatyczne z wczesnodziecięcymi traumatycznymi doświadczeniami, łącznie z patologią więzów opiekuńczych. Celem uwiarygodnienia hipotezy opracowanie podkreśla daleko idące podobieństwo między konsekwencjami syndromu dziecięcej traumy (zespół DESNOS) a odległymi skutkami negatywnych doświadczeń ciała wraz ze zmianami funkcjonowania na poziomie

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neurofizjologicznym (teoria przywiązania Bowlby'ego, koncepcje relacji z obiektem, wyniki badań nad negatywnym znaczeniem doświadczeń ciała, modele karcinogenezy). Z drugiej strony przedstawiona hipoteza znajduje oparcie w szeroko akceptowanej roli aktualnego stresu wraz ze stosowanymi strategiami adaptacyjno-obronnymi. Znajdują one odbicie w kształtowaniu się wyróżnianych u dorosłych wzorów zachowania: A, C, D oraz ich znaczeniu (obok słabości konstytucjonalnej) jako czynników ryzyka psychosomatycznego.

Słowa kluczowe: etiologia zaburzeń psychosomatycznych, ryzyko psychosomatyczne, czynniki traumatyczne, trauma dziecięca, wzory zachowania (osobowości) A, C, D, więzi przywiązania, doświadczenie ciała, obraz ciała.

1. Introduction

The paper tackles the issue of psychosomatics and—in particular—the aetiology of psychosomatic disorders, which still has not been sufficiently explained.

Psychosomatics is a distinct branch of knowledge, whose sources can be traced back to psychoanalytical tradition and clinical research related to it. Customarily, it strives to explain the aetiology of some somatic disorders. A psychosomatic disorder is an illness afflicting the Soma (body), an illness that is influenced by Psyche (mental functioning), or that—in extreme cases—was caused by a mental state (Rosenhan, Seligman, 1994). Constitutional weakness of body organs, which in stressful situations gives way to various pathological somatic changes, is of no small importance. In a narrow approach, the emotional factor predisposing to psychosomatic disorders is anxiety alone (Korzeniowski, Pużyński, 1986, in: Dolińska-Zygmunt, 1996).

Unlike conversion disorders, in psychosomatic disorders symptoms do not substitute emotions, rather each emotional response is accompanied by changes in autonomic nervous system and endocrine system; their frequent occurrences may cause damage to the organs 'related to the emotion'. Chronic emotional tension creates favourable conditions for somatic disorders, and its sources may range from conflict situations and sense of threat to external factors.

Body of recent literature shows that the current understanding of somatic disorders has been considerably broadened—departing from its original, classic character—as explanations regarding the mechanisms of psychosomatic disorders refer to all somatic conditions, and recognize the importance of emotional and psychological factors in the development of said mechanisms.

The inspiration for this study was drawn from the empirical research on behavioural patterns and personality types A, C, D, as they are thought to be related to susceptibility to particular somatic disorders. The results suggest that the psychological mechanisms that are typical of these personality types converge with the consequences of traumatic childhood experiences. The attempt to explain these observations was based on the conceptions and data regarding childhood trauma (cf. Kubacka-Jasiecka, Kuleta, 2012).

2. The aim of the study

The aim of this paper is to provide support to the hypothesis binding the risk of psychosomatic disorders with the consequences of childhood trauma by gathering supporting evidence from the body of literature on the topic. It is the author's opinion that what is a significant factor mediating between child trauma and the psychosomatics of the adult are the common core characteristics of types A, C, D; characteristics that come as the aftermath of negative experience of non-empathic, dysfunctional maternal care, and that

translate into disrupted body perception, negative physical self, personality disorders, as well as pathological relationships with others.

3. The problem of psychosomatic disorders' aetiology

The problems stemming from the lack of a widely accepted definition, and the scope of the term of 'psychosomatic disorder' are associated with a variety of aetiological factors that are emphasised by different researchers. What is underlined in the literature on the topic is the complexity of aetiology, and the fact that there are psychological and biological predispositions, as well as environmental factors involved. The biological predispositions are understood in terms of genetic factors (vulnerability of certain organs), the sex of the person suffering, and the properties of the nervous system that determine individual susceptibility to the stress of critical events.

What gained considerable attention with regard to environmental factors was stress, together with the characteristics of reaction to critical (traumatic) events, and the coping strategies applied. Considering stress as a psychosomatic risk factor, it is necessary to take a broader context of its psychological aspects into account, including:

- the characteristics of stress situation (strength, recurrence, life-threatening intensity),
- relatedness (real or symbolic) to negative early-childhood experiences,
- relatedness to value hierarchy, goals and the sense of life of an individual,
- the characteristics of stress reaction style, including: susceptibility to a given kind of stress, perceptual patterns, as well as vegetative-somatic and emotional response patterns.

It may be assumed that a psychosomatic risk is linked to the lack of the ability to optimally mobilise the defences, and to dysfunctional or inadequate coping styles.

The set of **psycho-environmental** factors encompasses family atmosphere, personality, and rearing methods, which may result in:

- disturbances in experiencing body and physical self,
- formation of dysfunctional attachment patterns that continue into adulthood,
- adaptive-defensive types of personality and behaviours in adults.

4. Behavioural patterns as a psychosomatic risk factor

The idea of personality traits and their constellation (along with genetic factors and other properties of an organism) as facilitators of psychosomatic disorders was first proposed by F. Dunbar (1943). In time, the body of research on behavioural patterns (personality types) related to particular somatic disorders grew, which established their psychosomatic character. As a result, the following personality types—treated as psychosomatic risk factors—were identified: A, C and D; types that shape early in life and that tend to change very little during its course.

Behavioural patterns form on the basis of perceptual patterns—individual's typical ways of perceiving, interpreting and judging situations, as well as patterns of emotional response. According to K. Wrześniewski, they may be defined as "an individual's typical propensity to emotional reaction that is relatively independent from stress situation" (2005, p. 506).

These behavioural patterns are the consequence of the consolidation of a particular relationship between a situation and personality traits that determine the interpretation of the situation, and thus directly influence the behaviour. Furthermore, these traits are responsible for interpersonal relations, internal conflicts, and the lifestyle or life path choices. Long-lasting, recurring emotional states lead to the pathogenous physiologic changes, whose type depends on the intensity of emotions, as well as their duration and contents on the one hand, and constitutional

weakness of an organism on the other (cf. Aleksander, 1952; Lipowski, 1987; Reykowski, Krawczyk 1972).

Until now, three diverse types of unhealthy constellations of A, C and D personalities' properties have been described, and deemed to be in opposition to healthy types B and O (Denolett 2005; Mirski, 1998; Juczyński, Ogińska-Bulik, 2004; Wrześniewski, 1993).

Type A according to V. Price (vide: Wrześniewski, 1993), is grounded in three main beliefs:

- "it is important to constantly double-check oneself,"
- "there are no universal moral standards,"
- "all resources at one's disposal are insufficient to realise set goals."

Type A is a means of regulating individual's relationship with the environment, it is rooted in elevated need for achievement that is bound up with tendency for domination and aggressiveness. It is also related to some aspects of personality and temperament, as well as to situational factors (cf. Wrześniewski, Eliasz, 1988). It is characterised by extreme competitiveness, focus on life achievements, aggressiveness (sometimes strongly suppressed), subjectively experienced time pressure, haste in behaviour and speech, excitability, alertness, and excessive responsibility (Włodarczyk, Wrześniewski, 1998).

In his analysis of type A, Wrześniewski noted that the following issues still need to be addressed:

- does the risk factor stem from only some aspects of the type (e.g. hostility), or from the whole constellation of traits?
- does type A constitute a specific psychosomatic risk factor that can cause only specific disorders, and if so—which ones?
- what are the mechanisms mediating between type A and the disorder's development?

It seems that these questions, despite growing numbers of empirical inquiries, remain—to certain extent—unanswered; even more so, as they are also valid for all the outlined types, including C and D.

Type C (cancer prone personality) poses a serious psychosomatic risk factor; it was described in the context of research on oncology patients' personalities as a type decreasing immunity and thus predisposing to cancer (cf. the models of carcinogenesis by H.J. Baltrusch, or by M.E.P. Seligman, in: Dolińska-Zygmunt, 1996), as well as to rheumatic and gastrological diseases, or even to osteoporosis (cf. research results in: Kubacka-Jasiecka, 2006; 2012; Kubacka-Jasiecka, Wysocka-Pleczyk, 1998).

The most characteristic features of type C (Morris, Greer et al., 1981; Temoshok, 1987; Eysenck, 1988)—are considered to be the suppression of negative emotions (especially anger, anxiety, aggression), and the inability to constructively cope with stress. The concept by H.J. Eysenck, pertaining to type C (the so-called type no. 1), depicts it as a temperamentally (constitutionally) conditioned type of personality being located in the upper-left quarter of a plane divided by Neuroticism and Introversion axes (neurotic introvert). Type no. 2, neurotic extravert, would correspond to type A (H.J. Eysenck 1990, vide: Brzozowski, Drwal, 1995). Type no. 1 is characterised by low demand for stimulation, type C individuals are heavily dependent on significant others -severing the dependence bond is experienced as trauma, and leads to helplessness and loss of hope.

Moreover, based on empirical research T. Morris and colleagues (1981) underline not only the tendency to strongly repress and suppress anxiety and anger, but also the weak emotional expression, and the low levels of neuroticism—the so-called emotionally inhibited personality. Futile struggles with stress strengthen repressive experiencing and behavioural patterns. Furthermore, type C individuals are observed to show low self-esteem, and to lack self-acceptance, strong bond with life, and self-caring functions of self.

Type D, the distressed personality, was described by J. Denollet (2005). It is considered to extend over two main dimensions that are relatively stable personality traits:

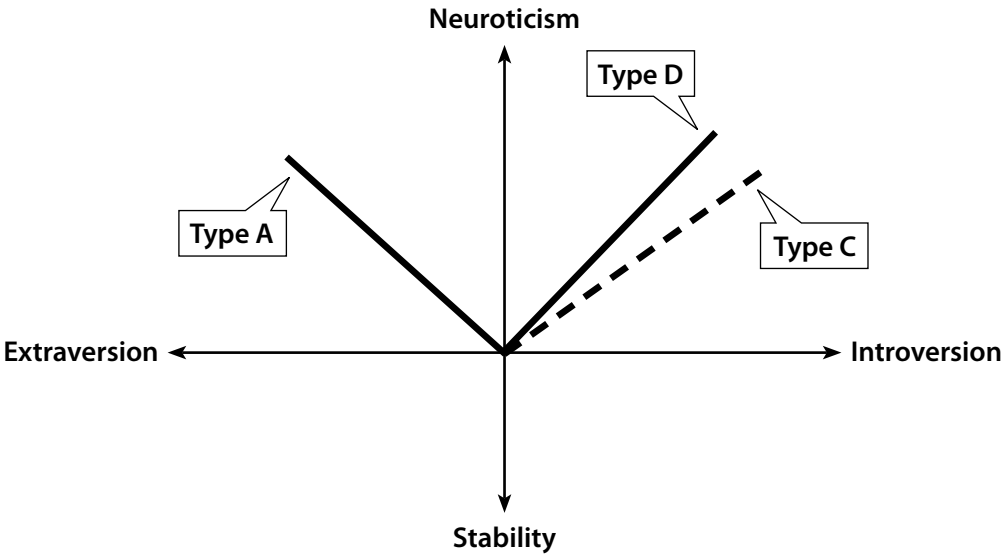

Fig. 2. Type D and other personality traits
Source: Ogińska-Bulik, 2009, p. 23.

- negative affection; occurrence of strong negative emotions—anxiety, anger, aggression, irritation (so-called being 'charged' or 'worked up'),
- inhibition processes that translate into social inhibition, and are related to the so-called inhibited temperament (a term introduced by J. Kagan (vide: Strelau, 2004)); they are complemented by developmentally unchangeable shyness and fearfulness that are connected with excessive control.

Type D individuals avoid difficulties and threats of social relations by refraining from expressing negative feelings and behaviours that would follow as their consequence. This conscious process takes place in social interactions, as it is being dictated by the fear of disapproval and rejection. Type D individuals are characterised by insecurity, low self-esteem, pessimism, depressive attitude towards life, weak bonds with other people, and a tendency to worry excessively. They were also shown to have an inclination towards self-blaming (Ogińska-Bulik, op. cit.). According to Ogińska-Bulik (op. cit.), type D individuals: "show much stronger symptoms of stress caused by experiencing traumatic situation, manifesting in overexcitation, and recurrent trauma imagery, but also in—albeit to a lesser extent—avoiding thoughts and emotions related to traumatic events."

The data presented so far may suggest that the diversity of behavioural types can stem from the connection they have with other threats that determine the choice of strategies of coping with stress. They trigger a variety of adaptive-defence mechanisms that define neurophysiologic reaction mechanisms, which—in turn—determine the probability of disorders as a consequence of chronic and specific stress stimulation.

In order to complement the above presented significance of stress for aetiology of psychosomatic disorders, it is necessary to try to characterise the behavioural patterns from the perspective of coping with stress (M.E.P. Seligman 2003):

- mobilising reaction of alarm and emergency is characterised by anxiety, fear, anger, hostility, and strong defensiveness; a typical feature of type A, being at risk of

hypertension, heart attack, and other cardiovascular diseases;

- de-mobilising reaction (neutralised or suspended biological mechanisms of emergency and activity) manifests itself with resignation, sense of helplessness, hopelessness and depressive conditions; a typical feature of type C, being at risk of cancer, rheumatism, peptic ulcer disease, coronary artery disease, as well as osteoporosis;
- particular susceptibility to stress, which evokes strong negative emotions, and the tendency to consciously control and curb them, is typical of type D—one that is especially prone to hypertension, asthma, or diabetes (cf. Ogińska-Bulik, 2009).

N. Ogińska-Bulik (op. cit.) compared and collated types A and C with type D by placing them on diagram stretching over the axes of Neuroticism and Extraversion—dimensions that are determined constitutionally (temperamentally) to a large extent, see: figure 2.

Individuals belonging to all the three types may be characterised as neurotic (on a medium level); in the case of type A they are neurotic extraverts, while types C and D may be classified as neurotic introverts, although type D scores a little higher on the neurotic axis.

In her study, Ogińska-Bulik (op. cit.) analysed the relationships between type D personality and the two other behavioural patterns: A and C. The former seems to bear more resemblance to type C than to type A. Personalities D and C share a tendency to refrain from disclosing emotions, while type C individuals are rather not well aware of the experienced stress, which tones down the negative emotions caused by it; they also have a tendency to repress such emotions. On the other hand, type D individuals, being fully aware of the negative emotions caused by stress, refrain from expressing their feelings due to fear of social disapproval and rejection. It is typical of both types, C and D, to react to stress with helplessness, sense of hopelessness, pessimistic attitude to life, and depression.

Moreover, what type A and type D have in common is the component of anger and hostility. Each of them, however, is determined by different factors. In type D it is linked with interpersonal relations, and in the case of type A it is connected with individual's frustrated need for success and control over the environment. Type A individuals are more likely to show negative emotions, while type D refrains from expressing aggression. In stressful situations, both types are reluctant to make use of social support.

A. Mirski (1998) attempted to determine the similarities between types A and C. He pointed to a specific combination of aggression and anxiety that both types have in common. The difference he postulated is that type A suppresses anxiety, while type C suppresses hostility. The lack of self-care and healthy behaviours, which is observable in both cases, is accompanied by hostility in type A, and by self-destructive behaviours in type C. Both type A and type C individuals are characterised by conformism, lack of autonomy, and dependence on their environment. Those traits, however, do manifest differently. In the case of type A it is the conformism of goals—the strive for environment's approval by achieving socially highly valued success. In the case of type C, on the other hand, it is the conformism of means—undertaking activities that are approved of and recommended by significant figures, functioning under the environment's pressure. Low self-esteem and low self-worth are typical features of both types, although type A tends to compensate for it with rivalry and by achieving successes. It is also not atypical for them to experience little joy in life, low mood, and even depression.

Therefore, seemingly distinct behavioural patterns A, C and D can be interpreted as established, habitual adaptive-defensive behaviours, individually diversified strategies of child's struggle for safety and parental love; strategies that are determined by both constitutional and environmental factors. What may seem surprising is similarity, or even the convergence, of typical behavioural patterns

with the characteristics of functioning of individuals that fell victims to dysfunctional past. By hindering the development of mature autonomy, child trauma favours the shaping of inadequate strategies of coping with the attachment trauma. Behaviours that are unconsciously repeated year after year disrupt the psychosocial functioning of adults, paving the way for psychosomatic disorders. It needs to be stressed that, despite the close relation between body, neuronal and mental functions, to the author's best knowledge, in the literature of the subject there are hardly any reports of relationships between the aforementioned behavioural patterns and childhood past experiences, together with disturbances of physical self.

5. Childhood trauma

Post-traumatic stress disorders come as a consequence of experiencing a safety- or life-threatening event as either a subject or a witness (Lis-Turlejska, 1998). Their development is explained by the concepts of neurological and psychological oversensitivity. What seems most important are the arousal mechanisms' disruptions (Dudek, 2003). Severe stress causes tension, and overreactivity of sympathetic nervous system, which is the basis of chronic tension (not excluding muscular one; but also of irritation and constant alertness), as well as anxiety and somatisation disorders. The theories of psychological oversensitivity underscore the fact that trauma occurs when the intensity of traumatic stimuli breaks through the stimulus barrier (a term taken from Freud, vide: Dudek, op. cit.; Lis-Turlejska, 1998).

In the case of childhood trauma (the so-called DESNOS syndrome) there is the problem of chronically recurring threatening events and circumstances, whose pathological consequences are described as the so-called Disorders of Extreme Stress Not Otherwise Specified. It may result from child negligence, emotional rejection and maltreatment, and most of all—from sexual abuse (Gaskill, Perry, 2012; Goodyear-Brown, 2012).

The syndrome is often accompanied by symptoms of other disorders, significantly contributing to the deterioration of family and social functioning. Traumatic experiences resulting from overgeneralisation and false associations lead to stiff imbalance, in which even neutral events are perceived and interpreted as negative and threatening (Kiecolt-Glaser & Newton, 2001, vide: Gaskill, Perry, 2012; Sikorska, 2012).

Traumatic experiences increase the risk of deep emotional, cognitive, behavioural and social (weak socialisation) problems related to physical health (Perry & Pollard 1998; Anda et al., 2006; Perry, 2006 vide: Gaskill, Perry, op. cit.). J. L. Herman notes: "Traumatic event disturbs human autonomy on the level of fundamental physical integrity... The body, was assaulted, hurt, dishonoured" (1998, p. 64). And then he continues: "The identity developed before the traumatic event is irrevocably destroyed" (p. 68). In the case of trauma, the younger the child, the greater the risk.

The symptoms of disorders are particularly strong in sexually abused children, manifesting itself in greater vulnerability to being hurt, dysfunctions in arousal regulation, and inhibition of emotion expression, especially with regard to the negative ones. It was observed that such children are, as Herman put it, "unhealthily attached" to significant others who neglect or maltreat them. A defensive idealisation of the oppressing parent was observed, as well as the transference of anger onto the nonaggressive parent. The defence mechanisms in such children resemble the so-called Stockholm syndrome, which was discovered in abducted hostages, and in concentration camps' prisoners, etc. The climate of constant terror, and the unpredictability of violence lead to automatic hyper-obedience of children. The harm done to a child is removed from the consciousness and from memory by means of intentional suppression and denial that lead to repressing one's own experience, while the primary adaptive goal

is to "maintain original attachment to parents in spite of everyday evidence of their ill-will, helplessness or indifference" (Herman, op. cit, p. 112).

Experiencing guilt and self-blaming are typical. Thinking about oneself as of "something disgusting" becomes the germ of "stained" identity, one that is "marked with sin". Assuming responsibility ("I was the one who provoked it") provides the sense of being in control of the situation.

Victims develop the so-called doublethink, a splitting of self-image into sanctified self and despised self; thus the personality is fragmented, as well as the representations of other people. A. Miller complemented the picture the following way: "the less love a child received, and the more he or she was rejected and maltreated under the pretext of rearing, the more the adult is attached to his or her parents or other people, onto whom his or her expectations were transferred in the hope of one day being satisfied at last" (2006, p. 14).

M. Czub (2014) notes that the disorders of individual children depend on the context and the situation, in which they are harmed—or abused in particular. The trauma results in a variety of individual differences, in particular: the development of susceptibility to harm, as well as the scope and the magnitude of resulting disorders.

6. Dysfunctional attachment relation

Early childhood dysfunctional bonds and negative family experiences mark and pathologise development processes (cf. Józefik, Iniewicz, 2008). Therefore a question arises, whether experiencing chronic lack of safety, helplessness and emotional turmoil by youngest children (not only by victims of oppressive and violent rearing) may be considered a source of trauma? The researchers specialising in the field of childhood trauma agree that chronic state of 'unspeakable terror', overwhelming solitude and helplessness continuing from the earliest years meets the definitional criteria of trauma. O. Sakson-Obada states directly that: "(...) the results of such experiences as long-lasting separation of a child with a caregiver, emotional damage and negligence, as well as physical negligence are severe enough to classify it as trauma" (2009, p. 63).

Experiencing disruptive anxiety, withdrawal, and deep depression, which add-up to form the so-called cumulative trauma, is the reason for problems with regulating emotions, controlling impulsive social behaviours, and many other forms of mental disorders typical for post-traumatic conditions. The consequences of chronic child negligence are more devastating to personality than other single acts of violence, be it physical or sexual (cf. Iwaniec, Sneddon 2002; Herman, 1998; Van der Kolk, 2003).

The issue of early-childhood maternal bond pathology as a psychosomatic risk factor is addressed by a number of conceptions that can be divided into three separate paradigms in psychological research: object relations theory, attachment theory, and the approaches stressing the role of body experience and physical self forming as a mental representation of the body.

The above-mentioned theories lay stress on the negative influence of dysfunctional character of early relations with mother (caregiver) on the personality and later functioning of children (the so-called unresolved attachment), as well as on the psychosomatic symptoms that come with age. In the following part of the paper the above-mentioned approaches will be briefly summarised with a highlight on the aspect of body experience disruptions which is more or less directly present in each of them.

Object relations theories trace the sources of developmental disorders to pre-Oedipal developmental phase and to the shaping of mental structure (cf. Cierpiałkowska, 2007). The quality of early-childhood experiences with mother expresses itself—as a result of their introjections and internalisations—in positive and negative representations of self-object-affect, constituting an early stage

of what later becomes personality. Mother's empathic care, considering child's emotions, causes more and more integrated representations of self and other people from the environment to emerge (Krueger, 2000). One's own body may be experienced as a 'safe whole' or as sensational chaos dominated by the unthinkable anxiety, which Winnicott (1971) calls 'the fear of breakdown of continuity of existence'.

Failure in shaping positive relation appropriate for child's age and for child's need of object relations hinders future separation and independence from mother; it also results in frustration, anger and prevalence of primitive defence forms. The conflict between positive and negative representations of mother figure makes their integration impossible, disrupting child's normal course of development.

Disorders are the result of coming to a halt during the third phase of development, which is caused by unsuccessful differentiation between the representations of self and object, which in turn results from constitutional predispositions, insufficiency of positive relations with mother, and/or from experienced traumas. In order to maintain positive relations with mother, it is necessary to separate by means of the mechanism splitting internal representations of self-object, the positive ones from the negative ones, protecting from the painful experience of the loss of the ideal object. The domination of the primal mechanisms—splitting and projection—also serves a defensive purpose (Kernberg, 1976; Cierpiałkowska, 2007).

Attachment theory, by J. Bowlby (2007), characterises the influence of child's early relations with significant others—especially with mother—on emotional development, and particularly on the occurrence of separation anxiety. Drawing on psychoanalytic thought, ethology, and object relations concept the theory considers emotional bonds between a child and a mother figure to be instinctive and based on biological mechanisms. What is crucial, is mother's attitude; the shaping of attachment patterns depends on her empathy, appropriate 'resonance' with child's needs, adjusting to them, as well as on frequency and quality of mutual contact. The so-called models and working schemata—cognitive-affective schemata of self and attachment figures, and mutual relations between them—are formed on the basis of child's relations with caregivers. Due to their pre-verbal stage of development the schemata are sensorimotor and extraconscious in nature. In time, by the means of symbolising function they may become conscious and possible to verbalise, although it is not necessarily always the case.

J. Bowlby (2007) underscores wide, far-reaching consequences of destructive attachment; child's growing frustration and anger, anxiety, and the difficulties in controlling and expressing emotions. Improperly formed bonds may cause anxiety, proneness to depression, low self-esteem, sense of helplessness, chronically increased tension, and aggression. It may also lead to social isolation and alienation. Other features that are not uncommon in such situation include lack in social skills—the ability to correctly assess others and one's relation with them, which translates into suspicion, distrust, and inability to benefit from psychosocial support at times of trouble. All this may be observed in individuals who are characterised by behavioural patterns that are thought to constitute psychosomatic risk factor.

Bowlby's colleagues and disciples distinguished four patterns of attachment that correspond with attachment styles in adolescent and adult relationships: secure, ambivalent, avoidant, and disorganised (confused). They can be described in two dimensions: dependence–avoidance and positive–negative evaluation of oneself and others. The last three of the above-mentioned styles are classified as disturbed, i.e. insecure (Ainsworth et al., 1978; Ainsworth, 1982). Emotional overload, which comes as a result of dysfunctional relation with mother, causes all subsequent interpersonal relations—including the neutral or potentially secure ones—are perceived and

experienced as threatening, also during later periods of life. Negative image of oneself and other people, as well as propensity for dependence, or avoiding close relations are not without significance as well.

7. Childhood trauma vs body experience and physical self disorders

Negative experience of one's own body, symptoms related to experiencing one's own physicality—somatisation states, not solely psychopathologic states are increasingly often becoming the focus of trauma studies, especially trauma related to early childhood; consequences of sexual abuse of children not excluding. It is currently emphasised that traumatic experiences influence not only the functioning of the brain but the whole nervous system, hormonal balance, muscle tonus, and the dysfunctions of the autonomic nervous system. To summarise it with a quote from R.C. Scaer: "Trauma causes physiological, neurobiological, endocrine and immunological changes, which express themselves in the illness. Trauma changes the brain, which changes our body" (vide: Schier, 2005, p. 84).

K. Schier, who is one of the few Polish researchers to address the issue, defines body image in the following way: "It is a complex process of experiencing oneself in the physical way, a phenomenon that I locate at the borderline between the inner world of a given person and that person's relations with other people" (2010, p. 9). Physical self refers to the whole range of physical experiences on the surface and within the body; it involves three fundamental dimensions: mental experiencing of physical sensations, experiencing body functions and their disruptions, and the body image, its cognitive representation.

A child that is a victim of dysfunctional caring relations develops a particular type of emotional regulation, which refers mostly to bodily sensations (this is true in the case of children aged around 4 months (cf. also Mahler et al., 1975 vide: Schier, op. cit)). In the following stages of physical development body's boundaries are discovered, various sensations both from the body and from the reality outside of it are discerned, and a stable representation of one's body and physical individuality is developed.

The difficulties in developing physical self result in a number of its disturbances. All child's negative experiences, despite being repressed from consciousness, remain 'carved' in body. Thus, the body becomes a "keeper of our history" to refer A. Miller (2006, p. 21), and "it strives to ensure we can live with our truth". The body "tries to make us aware of our history by the means of various ailments, so that we can understand the once abused and humiliated inner child".

D.W. Krueger (2002) provides a list of development conditions that, in time, lead to disorders of physical self:

- intrusive and excessive stimulation by mother, resulting from her chronic need to remain in a state of fusion with the child—in such a case, one's own body is experienced by a child, as little, immature or asexual. This is the case in anorexia or other various forms of body autostimulation in reaction to danger (defensive body control or restoring vividness of body sensations).
- inaccessibility of empathic mother leads to difficulties in determining body boundaries, and in identifying inner body signals. Traces of this regularity can be found in mechanisms of functioning in borderline personality, and in individuals suffering from bulimia or depression (cf. Cierpiałkowska, 2007). Other, distant consequences consist of compulsive sex, frequent masturbation, and self-mutilation (increasing the sense of vitality and awareness of one's body).
- inconsistency in rearing, and traumatising unpredictability of adults' behaviours shape the so-called dissociated image of reality (lack of continuity, elements of images and threatening experiences).

Carers that focus on physical aspect of child's experiences communicate to the

child that in order to earn parental interest and acceptance the child should make pain and illness the leitmotiv of one's organisation of experience. According to D.W. Krueger (2000), the hampering of child's development expresses itself in regulating tension 'through body'. It is what happens in the case of eating disorders, self-mutilations, undertaking overly demanding physical activities or extreme sports, or psychosomatic problems. K. Schier states: "The gap between body and mind is bridged not only by psychosomatic disorders, but also by intense stimulation within the body or by damaging it" (2005, p. 30; cf. also Anzieu, 1979; Schier, 2002).

Inhibited body development manifests itself in experiencing emotions on the level of their somatic component—a regression (primary or secondary) of somatisation and symbolisation of feelings takes place. These phenomena obstruct the development of reflective function, which requires introduction of distance (space) between a sensation and its expression; a space where thoughts and words related to emotional experience can occur. A person that is lost in the turmoil of unnamed emotions and experiences remains incapable of integrating the physical and the mental selves.

Disruptions of experiencing one's corporality are caused to some extent by deformations of proprioception and skin sensations that are the outcome of lack of empathic touch and bond with mother—inadequate physical closeness in early stage of development, which is felt as threatening to safety and life. According to R.C. Scaer (already cited by K. Schier, 2005), the tendency to express hurtful emotions in the form of physical symptoms is found in people who experienced the trauma of being hurt by others, also in the sexual sense. It is related to the inability to grasp these traumatic experiences with thought or word, and to remember them. The feelings expressed in body are accompanied by the denial of experienced emotions, their repression, and accumulation of the so-called counter-energy (in the form of shallow breath, muscular tension etc.), which cause mental numbness (Lowen, 1995). Primordial physical experiences bring terrifying chaos called 'the fear of breakdown of continuity of existence' by D. W. Winnicott (1971).

Inappropriate relations with environment, relations that hurt a child, hinder the development of physical self, strengthen the processes regulating emotional tension 'through body', in the form of symptoms of somatomorphic disorders, including conversion, dissociation, as well as psychosomatic disorders. The inability to capture trauma in verbal narrative is the reason why "experiences originating from body become cut off", "displaced" from one's own body (Schier, 2005, p. 82). "It is the body that is ill, the body of a person who is not or was not loved as an autonomic human being, and what is more, a person whose body was or is to play a particular role for his or her psyche... When the soul suffers, the body ails", writes K. Schier (op. cit, p. 89). When under threat, by internal and external factors alike, the attention shifts towards physical self, as the most fundamental structure organising experience.

The structure that emerges is called, by D.W. Krueger (2000), a false physical self, one that is a defence constellation—body and physical self (embodied self) serve the 'internal object' instead the real, one's own self and its real needs. Physical self ceases being authentic -a person 'has a body, but does not experience it as his or her own body', 'he or she is not their own body'.

Psychotherapeutic process of restoring to consciousness memories—imprinted in one's body—of previous negative experiences eliminates the possibility of thoughtless release of deep emotions through one's own body, as it removes directing them against oneself or others from the set of available options (Miller, 2006).

Summarising, disruptions in experiencing one's own body by victims of early-childhood trauma boil down to the following:

- reducing the ability to experience sensual stimuli and pain (similarly to alexithymia),

- lack of control over body, experienced emotions and their expression,
- lack of body acceptance, and negative self-evaluation of it,
- alternating opposing physiological reactions: activation (of sympathetic nervous system) and lowering the tension, resignation (activation of parasympathetic nervous system), which leads to particular physiological function disorders (cf. Dudek, 2003),
- tendencies to aggression and autoaggression, as well as sense of helplessness, which result in neglecting organism's needs, and resignation from self-care in favour of survival.

8. Experiencing body and psychosomatic disorders

Polish subject literature relatively rarely associates the problem of psychosomatic disorders with physical self disturbances, even though somatic illness is connected with the body: "In most cases, psychosomatic symptoms are not associated with their actual cause," which, according to J. Herman (1998, p. 129), is thought to be rooted in a traumatic history of childhood.

Both traumatic events and inappropriate mother–child relations change the way an organism functions in the first place (Kendall-Tackett, 2012; Van der Kolk, 2003). Body becomes threat sensitized and vulnerable to stress. Perceived danger activates three systems of an organism: fight-or-flight, HPA (hypothalamic–pituitary–adrenal axis), and the immunology system, whose reactions increase the risk of many somatic (psychosomatic) illnesses. What is meant by somatisation is a temporary mobilisation of somatic reactions as a countermeasure against stress and mental pain.

D.W. Winnicott (1993) conceptualises psychosomatic disorders as a consequence of unsuccessful integrative role of ego—a split of psyche and soma, and an instance of regression to primitive defence strategies of coping with danger.

Illness is sometimes called a bridge between mind and body, because "(...) every psychosomatic symptom bridges, in a way, the mind and the body" (Schier, 2010, p. 86). A relationship, which loosens during normal development (desomatisation), during illness is being restored in a way; it is created as new, together with regression to affect somatisation. The bridge between the body and the mind is constructed not only of psychosomatic disorders, but also of intense stimulation within the body, or self-mutilation (cf. Anzieu, 1979; Schier, 2002). In Jung's concept, body becomes a personification of mental Shadow, which leads to psychosomatic symptomatology or self-mutilations (ibidem). "The narrative of attachment patterns may find its expression in a language of a body in illness" (Stora, 2007, vide: Schier, 2010, op. cit.).

According to A. Miller (2006, p. 57), individuals suffering from psychosomatic disorders "sacrifice their body (offer themselves) in order to protect the inner image of a parent". Having referred to writer Marcel Proust, she quotes from his letter to his mother: "For I would rather suffer from asthma and be as you like me, than cease to suffer and be to your liking." The fragment shows his awareness of the origins of the crippling affliction, and its psychosomatic nature. On the same page Miller adds: "body talks to us through illness, various ailments. Its language cannot be understood as long as we fail to see our denial of the truth of our own childhood. (...) the denial about personal truth driven them [her patients—added by D. K.-J.] to serious illness and early grave".

The thought may be enriched by a quote from J. Herman (1998, p. 19–20): "Maltreated children (...) are capable of evoking significant, if temporary, changes of emotional state by the means of deliberate activation of autonomic nervous system, or provoking its dysfunctions. Diarrhoea, nausea, compulsive sexual behaviours, compulsive risk-taking or hazard exposure, as well as ingesting

psychotropic drugs—all these methods are used to regulate internal emotional states. Thus, maltreated and/or abused children attempt to eliminate chronic dysphoria* and simulate—even briefly—internal state of well-being and satisfaction, which would be unattainable by any other means".

This situation worsens during adolescence, affecting future life and functioning in adulthood. The remarks and opinions of researchers in this field point directly to somatic consequences, including illnesses, early-childhood and subsequent traumas, as well as dysfunctional relations of infants with their mothers and carers.

The research by R. Liedte (1990, vide: Gracka, 1993) characterise the parents of young psychosomatic patients as overprotective, emotionally distanced, and depreciating child's important needs; it was also typical of them to exert pressure that deprived the children of independence. According to G. Rodin (1991, vide: Gracka, op. cit.), the somatic symptoms serve the purposes of regaining closeness with mother, protecting from separation anxiety (symbiotic phase), or from the loss of object; they aim at recreating closeness and uniting with mother. This way, a somatic symptom may become a means for expressing thoughts, a communicate that the mother is capable of reacting to (child's emotions assume 'somatic' form). The ability to tell mental experiences from somatic sensations largely depends on parents' discerning attitudes.

The concepts proposed by object relations theorists, and self psychologists postulate that in the cases of individuals who are somatically ill and who have dysfunctional personalities early-childhood physical experiences disrupted the process of mental structure formation. As a consequence, such individuals do not distinguish between the realities of inner experiences (identification with one's own, internalised self or object) and real self, or the relation with real people, which may manifest itself in abrupt oscillations of feelings and mood swings, shifting from internalised image of self to object, and back again—as in the case of e.g. borderline personality (Kernberg, 1976; Cierpiałkowska, 2007). Expectations and needs of others (object) become primary regulators of emotions and behaviour, from which individuals symbolically try to free, and become independent. Illness draws attention, it allows to avoid confrontation with mental pain and real problems.

It comes as no surprise that research on children—victims of trauma, particularly of sexual abuse (CSA syndrome)—also describe disrupted regulation of physical states (such as sleep/wake cycle), eating, excretion, gastrointestinal disorders, and many other internal organs (cf. Loewenstein, 1990; Demitrack et al., 1990, vide: Herman, 1998). Some scholars cited by J.L. Herman (1998; Hoppe, 1968; Krystal & Niederland, 1968) also point to other frequent somatic symptoms, such as: back and pelvis pains, dyspnoea, heart pains, or increased pulse. In the case of anorexia what was underscored was the dissatisfaction with one's own body; the rigorous control of its functions was interpreted as a defence from overwhelming emotions of turmoil and helplessness (Perry & Pollard, 1998; vide: Gaskill, Perry, 2012).

9. Summary and conclusions

The aim of this paper was to introduce and support the hypothesis linking the symptoms of psychosomatic disorders with earlier dysfunctional relations of child and mother (carer). Furthermore, it was the author's intention to show that not only the traumatic events, such as real rejection, negligence, maltreatment, or sexual abuse of a child, remain the fundamental factors of psychosomatic risk. The role may also be played by family relations that, although seemingly normal, are

* By "dysphoria" Herman means: "a state of being lost, a sense of emptiness, terror, anxiety, anger, sorrow, above all else unspeakable solitude" (1998, p. 117).

devoid of empathic maternal care that would meet child's needs. The relations with mother that fail to provide sense of safety, and that introduce emotional turmoil may result in somatisation processes, and in susceptibility to stress of critical events.

1. In the light of the thesis introduced at the beginning, and supported by evidence from researchers from fields that until now have been regarded as separate, it may be concluded that the so-called 'psychosomatic process' has the following characteristics:
   - at its onset there is the experience of a broadly understood loss, the experience that—if not worked through—results in a particular predisposition, body's oversensitivity to challenges and failures encountered further in life; additionally, the presence of a set of neurotic features is also important;
   - changes in organism's physiological functioning lead to long-term deregulation of autonomic nervous system, and to chronic muscular tension;
   - the chronic tension together with structural changes in internal organs can, in time, result in a variety of symptoms of psychosomatic disorders;
   - disruptions of body functions occur as an effect of defensive recession of desomatisation process.
2. The influence of early-childhood traumatic events on health does also take place indirectly (the psychological way of the so-called psychosomatic risk). It is characterised by:
   - negative, instable image of real self, and the relations of self with environment;
   - dominance of negative physical self over other aspects of one's self; it may be accompanied by: loss of control over body functions, and somatisation tendencies;
   - inhibition of emotional expression and verbalisation of feelings, as well as their somatisation.
3. Traumatic, pre-verbal experiences that are 'carved' in the body result in the so-called insecure patterns of child attachment that form, diversify and stabilise during the course of life.
4. Experiencing trauma together with threat to sense of safety may lead to forming of defensive-adaptive behaviours—unhealthy types of personality that are characterised by:
   - negative emotionality—tendency towards anger, anxiety, depression (types A, C, D);
   - controlling and suppressing emotional expression and emotional verbalisation (anxiety in type A, anger and hostility in types C and D);
   - threatening world image, and insufficient self-caring functions (in type A stress causes overly strong mobilisation, alertness and anger; in types C and D it results in insufficient mobilisation, overly strict control and repressing emotions, and social inhibition);
   - potential tendencies towards escapist addiction, impulsive and hazardous behaviours (the ground for it in type A is aggression, hostility and competitiveness, and in types C and D—tendencies to self-blaming and to self-destructiveness).
5. During adolescence and late adulthood the continuation of the child defensive-adaptive behaviour (attachment patterns, personality types) may be observed.

Apart from clinical evidence methodologically sufficient verification of the proposed thesis requires objective empirical research, including longitudinal studies, which can combine complementary perspectives pertaining to:

- long-term consequences of dysfunctional attachment relations,
- disturbed experiencing of body and physical self as factors mediating between experiencing trauma and disruption of organism's functioning,

- the role of identified behavioural types and types of personality (together with their psychoneurological mechanisms) treated as psychosomatic risk factors.

Both the results of previous psychological research, and the impressive achievements of neurosciences, physiology and psychology of child trauma reaffirms the hope that the full explanation of psychosomatic disorders can be found, as well as effective prevention and treatment.

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