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Book Review

It's All in Your Head

by Suzanne O' Sullivan. 2015 Chatto & Windus

One of the greatest challenges for most doctors is the struggle to believe in the truly subconscious nature of our patients' psychosomatic symptoms. If we cannot believe in that, we are doubting the integrity of every patient we see, whether we say it aloud or not. As soon as a patient is given a diagnosis of a functional disorder, this is their first concern; 'They think I'm doing it on purpose'. To understand the subconscious nature of our patients' symptoms is difficult but absolutely necessary for both patient and doctor. This is the goal of this wonderfully compassionate book by Dr Suzanne O' Sullivan, 'It's All in Your Head'.

O' Sullivan artfully eases us into this understanding by starting off with notions we already take for granted. All of our bodies produce physical symptoms in response to emotional distress. If you are nervous your hands shake – that is your body changing physically in response to an emotion. Physical symptoms may be experienced alongside stress, but they can also be experienced in place of the emotional upset. The physical symptoms are real and may be quite dramatic and disabling, but they are arising in the subconscious rather than being due to a brain disease. This process of dissociation does not occur deliberately. You cannot make yourself unconscious any more than you can deliberately blush. If there is a memory or emotion that is too painful for a person to experience, that emotion is converted into a physical disability as a sort of protective mechanism (Bowins, 2004).

Transient somatic symptoms resulting in illness without long-term disability affects one in four of the population. Somatic symptom disorder affects one in a hundred and, as Dr O' Sullivan knows only too well from her clinical practice as a consultant neurologist at the National Hospital for Neurology in London, is often very reluctantly accepted by patients. Proof usually requires evidence to support the truth. But the diagnosis of psychosomatic disorders is one of exclusion, when organic disease is sought but not found. A psychological assessment may be indicative; however, many patients believe seeing the psychiatrist means losing all validation of their suffering.

The denial of stress seems to be inherent in conversion disorders. If unpleasant emotions have indeed been converted to a physical symptom, the patient is not always aware that they ever existed in the first place. That makes it difficult for scientists to study the association between stress and the onset of symptoms. In order to try and establish the type of triggers that might lead to psychosomatic illness, a group of scientists compared people with a recent diagnosis of conversion disorder with those recently diagnosed with an organic disease. They did not ask the patients to identify a stressor but instead showed them a list of life changes or possible traumas and recorded every event that they had encountered in the previous year, irrespective of whether or not the patient considered it relevant, or stressful. The respondents with functional illness were twice as likely as the others to have experienced a significant life event in the year before they fell ill (Roelofs et al., 2005).

O' Sullivan takes us through the history of our current understanding of functional disorders, starting with Hippocrates' descriptions of hysteria as a wandering womb in 400BC. Galen was the first to suggest that one organ might change or react in 'sympathy' for another, how a disease of the stomach might travel in spirit form through a nerve to the brain resulting in fainting or a seizure. By bringing the scientific study of hysteria to the fore again in the 1800s, Charcot created a plague of hysterical seizures that quickly spread throughout Europe. Janet developed the idea that the subconscious and conscious awareness were separate entities. He believed that dissociation arose as a result of psychological trauma. To Freud and Breuer, hysteria was an unbearable memory or feeling made palatable by its conversion to a somatic complaint. To treat the patient, it was necessary to uncover the lost memories.

O' Sullivan brings us all the way up to the present with many interesting studies such as one using MRI to look at the brains of patients with psychogenic paralysis. A clear difference has been demonstrated between healthy volunteers moving a limb, patients with psychogenic paralysis trying and failing to move a limb, and another group of healthy volunteers asked to feign not being able to move their limb.

O' Sullivan also addresses factitious disorders and malingering. Conversion disorders are subconsciously generated, and the patient is mystified to discover that no organic disease has been found. In a factitious disorder, the affected person has an awareness of the lies they are telling but they do so out of a need for a certain kind of support and attention. Often they are unaware of their own motivation and cannot control their own behaviour. Malingering, however, is quite different. It is a deliberate feigning of illness for financial gain, to win a court case, to avoid conscription. The Diagnostic and Statistical Manual (DSM) does not consider malingering to be a medical diagnosis. It can be difficult, however, to parse out these three distinct diagnoses.

O' Sullivan inspires with her compassionate approach when she reminds us that exaggerating to convince is not the same as exaggerating to fool. Some cries for help are louder than others if they have previously gone unheard. Whether these cries are consciously or subconsciously generated, our goal should always be to understand and attempt to relieve our patients' suffering.

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