Symptoms, Dreaming and Society: Process-oriented Symptom Work as a New Approach to Illness and Disease

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Modern medical culture

Today's complex medical culture demands a change in how we perceive illness. Our subjective experience of symptoms and disease is predominantly influenced by social or cultural values. Modern liberalism has brought immense progress in actual social conditions, including economic, material and political freedom, as well as the spread of democracy as a political structure. One pillar of this progress is individualism, which focuses on material and economic measures. Within this *Zeitgeist*, or timespirit (the sum of the current valid values of the local culture), health care has also concentrated on treating the individual, with enormous success. However, I believe that a future view of health will encompass mental, social, and spiritual well being. This expanded view will move beyond the individual to incorporate interpersonal relationships, community, culture, and spirit as intricate parts of disease causation, as well as the concept of *salutogenesis*, the generation and maintenance of health.

Modern medical views of illness and disease

The western biomedical approach is disease-oriented. Disease is defined as an abnormality in the structure or function of an organ (or organ systems). Young sees disease as a pathological state, regardless of whether or not it is recognized as such by the culture (Young, 1982). Such definitions assume that disease is somehow objective and culture-free. This materialistic or objectivistic worldview, which relies only on empirical data, has brought many beneficial advances in modern science. The detrimental side of this predominant attitude towards disease is that subjective experiences are reduced to the behavior of mechanistic processes. The inner experience of an illness, including its cultural meaning and the interpersonal relationships experienced by the patient, are not considered.

Three domains of experience

I believe that experience can be categorized into three different domains. Philosophers worldwide have distinguished between the realms of objective (it), subjective (I) and cultural (we) experience. These divisions are also found in the Three Jewels of Buddhism: Dharma or spiritual truth, the 'suchness' of every phenomenon; Buddha, which represents the enlightened mind in every sentient being; and Sangha, the community of spiritual practitioners. Each of these levels of experience is a world unto itself, with a unique viewpoint and mode of expression. In the last three hundred years, modern western science has concentrated on studying the materialistic "it" world and its worldview. The complex

spheres of experience have been reduced by the dominating mainstream value of our society to a one-dimensional worldview of objective and causal processes.

These two prevailing philosophical pillars of today's western society—the focus on the individual and the belief that empirical truth is the only valid perspective—also dominate our understanding and treatment of disease.

Psychoanalysis as a reaction to the dominant worldview

Psychoanalysis emerged at the end of the 19th century. With its focus on the subjective experiences found in dreams, psychoanalysis can be seen in part as a reaction against overly objective cultural tendencies. At that time, the objective focus in medicine was culminating in the work of physicians such as Virchow, Pasteur and Koch, who sought to prove that the only forces acting in the organism were physics and biochemistry. Freud introduced a counter-movement to the prevailing scientific views by seriously considering language and the rediscovery of the subjective sphere, evident in his interest in the meaning and interpretation of psychological symbols and symptoms, the world of the subjective 'I'.

Psychoanalysis explained some symptoms as an expression of neurosis. Such symptoms were seen as a "compromise formation" expressing the conflict between a forbidden desire and a censoring or repressive force. The roots of these conflicts were believed to lie in the early development of the child. This psychodynamic theory was originally based on hydraulic metaphors of the conservation of psychic energy. If emotional processes were blocked (through unconscious defense) the same quantum of psychic energy would be diverted through the brain and other organs, resulting in increased physiological arousal and structural lesions.

The psychodynamic theories prepared the ground for other therapists to develop psychosomatic medicine, which for the first time introduced psychotherapeutic treatment of symptoms. Because psychoanalysis was based on causal and mechanistic theories, as well as Christian morals, psychoanalysts also reinforced the notions of guilt and blame in the realm of body symptoms.

Recent developments in psychosomatic medicine

A growing trend sees disease as a chain of psychological factors, and the human being as a product of bio-psycho-social phenomena (Uexkuell, 1996). The overall situation of the diseased person, including her life circumstances, behavior and emotions, is seen in a social, cultural, economic and ecological context. Newer findings in the field of psycho-neuro-immunology describe the interwoven relationship between immunity, the nervous system, and the endocrine system, linking mind and body and challenging the reigning concept that body and mind are separate. After over two thousand years of division, the promise of reconciliation between body and mind brings hope for empathetic understanding to the ill. In bridging the gap between body and mind, psychosomatic medicine helps explain an individual's suffering. What could only be expressed through the body in terms of symptoms is now explicable through psychosomatic thinking, which offers relief from hopelessness. Seriously ill people can now actively participate in the healing process, and illness can provide a chance to react against the challenges of one's existence. As a result people who are ill gain increasing freedom. A person is no longer only the prisoner of an illness. The belief in the power of the spiritual, the psychological, the mental (mind over matter) can give remarkable hope to some patients and foster healing for many others.

While the new psychosomatic approach has allowed insight and healing, it has also had the opposite effect when it has been used to put a new dimension of individual responsibility upon the ill person. Repeatedly, the psychosomatic understanding of illness has been used to blame the ill for their suffering. As Susan Sontag writes, "patients who have unwittingly caused their disease are also made to feel that they have deserved it" (1978: 68). In the new psychosomatic view, the individual is often seen as responsible for disease, which is seen not

only as a frightening natural event but as a consequence of one's personal actions, emotions and life views. Health becomes a socially defined goal; disease a result of an incorrectly lived life. Sick people are seen as those who failed to stay healthy. In this perspective, becoming sick is closely related to guilt and shame and is experienced as a defeat.

When the onset and outcome of disease are directly ascribed to the afflicted, sick persons are subject to censure for personal failures that "caused" their condition. Blaming the individual threatened by adverse health further stigmatizes and victimizes the ill person. The causal understanding of disease co-opts the psychological realm of subjective experiences and concentrates on the individual's responsibility for her own suffering. For example, high-risk behavior leads to physical diseases such as AIDS. Repressed guilt feelings are thought to lead to psychological disease such as neurosis. This new psychosomatic view does not consider interpersonal relationships, community, culture and spirit as important forces that influence all levels of our well being. The risks of today's technical society and of power and rank phenomena in relationship are not examined as potential contributors to illness. This causal model of illness, which accuses and blames the individual, speaks loudly about our own culture and values. This view ignores the inherent complexities of disease, the cultural context of illness, and the environmental, socioeconomic and political forces influencing them. Susan Griffin rightly argues that a danger of the current practice of psychosomatic medicine is its paralyzing and concealing effect on "the politics of ecology." In perceiving each incidence of illness as a separate occurrence, whose etiology exists only in individual minds and bodies, environmental causes have been obscured.

> The irony is that though a psychosomatic approach to medicine has the potential to heal not only individual illness, but in its wider implications, our shared alienation from nature, the denial that commonly infuses this perspective blends almost imperceptibly with another unconscious belief, the illusory sense that human beings are neither dependent on nor really part of life on earth. But we are part of the earth, and the effects of ecological damage can be seen in the human body. (1999: 96)

The role of complementary medicine

Eisenberg (1993) described the demographics, prevalence and patterns of use of unconventional or complementary medicine in the United States. Findings include the following: Americans made approximately 425 million visits to providers of unconventional therapy during 1990; expenditures associated with alternative therapies appear similar to non-reimbursed expenses incurred for all hospitalizations in the United States; and the users of alternative therapies do not inform their primary care physicians. These findings indicate that alternative medicine modalities occupy a large role in the self-health care of U. S. citizens. They also stress the fact that there is an information or communication block about self-health care efforts between the patients and their primary care physicians. These findings document the growing defiance towards conventional medicine I often come across in my medical practice. They call for a renewed effort towards dialogue between health care providers and their patients. It is time to reflect upon the paradigms conventional medicine relies on. Mind-body dualism, the polarity between somatization and psychologization, and ignorance of differing cultural values are some of the reasons people mistrust the medical establishment. We need a new patient-centered medical paradigm, which sees and values the patient's subjective distress and connects it to her dreams, her social roles, her cultural values and norms, and her ecological context. I imagine and strive for a medical system that is aware of its own values and norms, and how they may marginalize other experiences.

The process work paradigm

Process work, developed by Arnold Mindell, Ph.D. and his colleagues, is an innovative approach to individuals and groups. Its view of body symptoms and disease is based on the idea

that there is a flow of life and wisdom behind illness, which can be unfolded by learning to follow body experiences. Symptoms are the direct expressions of a dreaming body. Like night dreams, they carry symbolic information. Rather than being pathological signs of the breakdown of the human machine, symptoms can be unraveled to bring meaning to a person's life. They mirror a disavowed inner story, which, with some support, can enrich the afflicted person. Process work sees personal growth and self-knowledge as resources in coping with disease. This perspective sees a connection between awareness of one's own psychology, one's role in society, and healing tendencies. Its focus is not only on healing but also on quality of life.

Process work has developed therapeutic skills and metaskills that are helpful for a systemic psychosomatic approach to disease. Dr. Arnold Mindell and Dr. Max Schupbach, pioneers in the field of symptom work and conflict resolution, facilitate clinics for people with chronic and serious body symptoms. Therapeutic work in these settings includes the above-mentioned social and cultural themes, which are discussed and processed in the large group. In this protective setting, issues around disease, which might normally be marginalized, can be brought to the awareness of the whole group. This leads to a deep feeling of community and helps to overcome the sense of isolation many ill people experience. At times, it also enables recoveries that are astonishing from the traditional medical point of view. I am deeply persuaded that it is now time to relieve illness of its individual context, and to implement the social dimension into the therapeutic setting. When we integrate the subjective experience of disease, completely different worldviews often emerge. Sharing this deep-rooted diversity has the potential to relieve the pain and suffering of entire communities and cultures, which suffer from one-sidedness, prejudice and discrimination.

Arnold Mindell (1995) also showed that rank, which is defined as the sum of one's inherited and earned privileges, has substantial influence on relationship. When we are unaware of rank,

communication becomes confused and chronic relationship problems develop. I therefore think that unconsciousness of rank on the part of health care professionals is one reason for the growing defiance towards conventional medicine and explains the information block mentioned above. Turning to alternative medicine, which has its own value, may also be seen as an act of empowerment for the health care receiver, and a reaction against the lack of rank awareness in the biomedical field.

Socioeconomic factors and health

Health is a social process, and poverty is a major risk factor for ill health and death. It is now widely known that the factors that define our social group also directly impact our chances of suffering illness or early death (Henderson, 1997). Health is closely related to socioeconomic status, gender, race, sexual orientation and age.

In the last century infant mortality dropped and life expectancy increased to an unprecedented degree. Although all segments of the population have improved health status and life expectancy, in most countries (predominantly developed countries) individuals of lower socioeconomic status (SES) have faced higher mortality rates than individuals of higher status (Kitagawa, 1973). As one moves up the SES ladder, morbidity and mortality rates generally decrease. Furthermore, there is at least some evidence that such inequalities in health outcomes have not diminished over time, and may have even increased in recent decades (Townsend, 1988). British Census data on mortality rates by social class over most of the twentieth century show a persisting gradient which is apparently increasing in recent years.

There is evidence that the association of SES and health occurs at every level of social hierarchy, not only for those in poverty. The most exciting results linking social status and health come from the Whitehall Study (Marmot, 1986; Marmot, Kogevinas, & Elston, 1987). This population-based longitudinal study followed more than ten thousand British civil servants for nearly two decades. Over a ten-year period, Marmot found that the age-standardized

mortality among males aged forty to sixty-four was about three and a half times as high for those in the clerical and manual grades as in the senior administrative grades. Additionally, there was an obvious gradient in mortality from top to bottom of the hierarchy. In none of the observed groups were people impoverished or deprived. All were employed, most in office jobs, with low risk from the physical environment. Thus, the usual interpretations of factors associated with low SES (lack of the material conditions of good health and high risk health behaviors) could not explain differences in the upper levels of social position. While some of the gradients in mortality were clearly correlated with smoking (high-ranking people rarely smoke, while low-ranking people often do), gradients were also observed in other causes of death unrelated to smoking. Moreover, the few high-ranking people who did smoke were much less likely to die from smoking-related causes. Other "individual" risk factors also failed to explain the gradient.

The researchers' conclusion was that something correlated with hierarchy per se influenced health. They argued that this factor was operating on all of us, not only on some underprivileged minority, and that its effects were large. Levels of self-actualization and self-esteem, which varied greatly from the top to the bottom of the ranking scale, were discussed as causal factors. In conclusion, SES, or social status in general, is a prevailing aspect of health functioning. In addition, the very existence of health inequalities violates many individuals' sense of equity and poses an important challenge to society as a whole.

Race, gender and health

Certain sociodemographic factors amplify the association of SES with health. Racism and sexism directly affect the health of women and nonwhites (Ehrenreich 1986;, Manton 1987; Reed 1986; Reddy, Fleming, & Adesso 1992). For example, an excess of black infant mortality beyond that explained by lower socioeconomic status shows a racial effect over and above the class effect. Blacks with the highest socioeconomic status (SES) have higher rates of infant

mortality than the lowest SES whites. Poor non-Hispanic black children are at the greatest risk of having elevated blood lead levels. Over 20 percent of them have high blood lead levels, compared with 8 percent of poor non-Hispanic white and 6 percent of poor Mexican-American children. Generally speaking, the morbidity and mortality rates are higher for blacks than for whites at most levels of SES, differing most at the low end of the SES hierarchy. Clear relationships have been found between ethnicity, SES, and residential, social, and occupational environments. Demographic research has shown that blacks in larger cities experience an extreme level of residential isolation and segregation from other groups. This is associated with exclusion from amenities, opportunities and resources that affect social and economic well being. This urges us to conclude that discrimination against blacks explains the described health disparities.

For many decades, being female was considered as a disease. Many physicians from the late nineteenth century to the early twentieth century held that woman's normal state was to be sick. Menstruation provided both the evidence and the explanation of this apparently physiological fact. The female reproductive organs, the uterus and the ovaries, were thought to direct the woman's entire personality and be a source of continuous ill health. The history of the bygone psychiatric disorder hysteria may be one of the best examples of this patriarchal attitude. Repression of memories and pathogenic ideas, among them improper sexual desires, were thought to cause the maladies. Their association with sexual abuse and trauma was well known by Freud, but was rejected because of the sexist values and beliefs of the time. The habit of aligning women with mentally induced, imagined disease still continues today. CFIDS (chronic fatigue immune dysfunction syndrome) is wrongly profiled to white middle class professional women and linked with some history of mental disturbance, making it the consequence of neurosis—another example of how womanhood is thought to undermine the

female body. Additionally it carries the prejudice against strong women and feminism. Furthermore, some male gynecologists still perceive menopause as a disease, which has to be treated with hormones, regardless of the woman's point of view.

In addition to the direct effects of racism and sexism, there are added burdens for nonwhite persons and women who go into a medical care system in which the majority of primary care givers are white men and in which women and nonwhites are kept to the "lower rungs" of the medical hierarchy (Weaver, 1978).

My personal point of view: the missing piece

In my opinion, what is missing in the medical world is a relationship and community-based therapeutic concept and way of thinking, which includes the systemic and cultural dimensions of health and illness. On the continuum of health and illness, the course or the outcome of disease depends, as we have seen, on many factors and measures. Medicine studies disease process; psychology studies personal history and individual relationships; social sciences examine the effects of society; and environmental sciences explore the problems of our global environment.

Newer educational curricula are no longer limited to specialized knowledge. More and more people recognize that solving our global problems requires experience from a variety of fields. Disease and illness as themes can no longer only be solved by medicine. Disease touches us in our entirety. It is partly related to our personal history, interpersonal relationships, and our economic and social status. Racism, gender issues, sexism, homophobia, ageism and healthism must, therefore, be an integral part of the view and treatment of the ill person. The psychological, social and medical domains are tightly interconnected and each of these fields profits when perceived in a more global or systemic context. Psychosomatic medicine is based on the psychodynamic theory of illness causation in which psychological conflicts are transduced into bodily distress. Health and illness are defined in terms of the interaction of mental and physical characteristics of individuals in response to their psychosocial environment. An expanded view on health additionally incorporates a sociosomatic model (Kleinman, 1986, 1995, 1998) that conceives illness and health as the embodiments of social events and conditions and integrates the social into psychosomatic thinking. Physiologic states become a metaphor for social and cultural processes.

Furthermore, cultural and social issues can no longer be left out of the discussion about good doctor-patient relationships. Therapists and physicians are responsible for more democratic relationships. An attitude of seeing the relationship as a form of a learning community, where people are interested in each person's individual culture, will help overcome power differentials between therapist and client. One way to understand the dynamics of the helper's and client's social background would be to discuss our various levels of rank and privilege. Every intervention could then follow the flow of the patient's inner and worldly stories. I imagine new relationship awareness where the health care provider tries to form an alliance with her client's inner and outer processes. She could then interpret so-called side effects, such as adverse reactions to a drug therapy, or lack of compliance from a patient, as a failure to connect with the patient's inner dreaming process or as a lack of understanding of the patient's societal circumstances.

Process-oriented symptom work differs from other medical and psychological therapies precisely because it includes societal questions of rank and privilege and an understanding of deep democracy (the value of all inner and outer parts) and community building. In encompassing the 'we-world' in the realm of body symptoms it helps to relieve the individual's burden—without denying that we all carry some responsibility for our symptoms—and puts the issue in a broader context. We all share the guilt and the beauty of our collective world. Symptoms may have meaning for the individual, but they are also an expression of the entanglement of our world.

A good example of this entanglement is the case of a 60-year-old Caucasian woman of German origin who worked on chronic bone problems in a seminar. She related her symptoms to growing up in Germany during World War II and suffering from malnutrition. She still remembers hearing the sounds of the bombing resonating in her bones. She has suffered from debilitating chronic symptoms all her life; her existence is dominated by fatigue and dizziness. She is so frustrated and fed-up with being a victim that she wants to jump out of her body and leave it all behind.

Dr. Arnold Mindell helped her unfold her process in the group. He expressed his compassion for the amount of pain and agony rooted in her historical background. Knowing his Jewish heritage, she was deeply moved by his compassion. She stated that she knew their stories could divide them and that she longed for a way to reconcile. Mindell recounted waking up singing the song of a man on his way to a concentration camp thinking: "Who says I have to be a calf on the way to slaughter, why can't I be a swallow flying free?" He helped her to disidentify with the tragedy and to stay in touch with her incarnated sentient essence. He encouraged her to leave the bone carcass and free herself from history. A calf that knows itself also as a swallow lives outside the finiteness of history.

As a woman of German descent living in the U.S. among a community of Jews, she was constantly exposed to overt and covert conflicts regarding Germany's role in anti-Semitism and the Holocaust. She kept the story of her own immense suffering as a young child in post-war Germany buried and felt further victimized by the collective processes she endured in her community. Besides the physical pain she experienced deep emotional and spiritual torment related to her biographical roots. The cause of her bone disease now included emotional and cultural suffering. Her personal and collective history were intricate parts of her symptom origins and actual experiences. To focus on them implied that she would continue to identify with her cultural context and feelings of

being a victim. Her process was instead to leave the old continent, her origins, and roots behind, and to "immigrate" to the new world. This would psychologically involve detaching from her identity as a German woman and from the sufferings she related to that particular identity. Detachment from her body experiences gave her a sense of freedom and revived well being. In this case the important and somehow paradoxical work was to help her not to focus too much on her body symptoms, at least temporarily. A one-sided psychosomatic approach would have burdened her with more strain and distress. The knowledge of and interest in the more global cultural context helped to facilitate her own inner struggling and relieve her from deep emotional conflicts.

Conclusion

The way people individually and collectively perceive and respond to health problems is shaped by the dynamics of many intertwined levels or parallel worlds. These forces resonate and reverberate in people's bodies and thus co-create the worlds of experience and body symptoms. The newer developments in neuroimmunology and neuroendocrinology, as well as stress research, help us to understand the mechanisms that link our subjective experience to bodily processes. Yet, the exact translation of thoughts and feelings into biochemical impulses remains a mystery. Rank or power differentials, income inequalities, and general social disparities are powerful factors influencing the mortality and morbidity of people. Social cohesion and social trust (Wilkinson 1996) are important in preventing health disparities on a cultural level. A sense of coherence (Antonovsky 1976), the ability to attribute meaning and purpose to one's life, and an inner sense of being connected to something bigger contribute to what Mindell (1995) defines as spiritual or psychological rank. This individual characteristic is an immense resource that protects us from the adverse effects of social dynamics.

I believe that myths, personal stories, and our inner dreaming have an influence on mechanics (the body). In a study done by Nerem, Levesque, and Cornhill (1980), rabbits fed a

cholesterol-rich diet and treated gently, with music played to them, had 60 percent less atherosclerosis than rabbits given the same diet, but under the usual laboratory treatment. Process work considers the inner music (self-love and self-esteem) and the outer interpersonal and social music (cultural context). By including the irrational dreaming aspects of our lives, it aims to nurture our sense of a coherent and meaningful world. Process work expands the definitions of health and disease by incorporating an understanding of the intricate role of cultural and societal contexts. With its knowledge and comprehension of the many levels of consciousness, it further deepens the realm of consensual body experiences.

Such an approach has the potential to change the face of our future health care. Many questions, such as the cost of an expanded health care system, remain open, but I strongly believe that we all need to collaborate in co-creating healthier individuals and communities by improving our understanding of the physical, mental, social, and spiritual components of health.

The denial of communal values is the downside of one-sided liberalism and individualism. Like Ken Wilber I think

> we are deeply confused if we imagine that individuals are islands unto themselves. Rather we as individuals are unavoidably set in deep contexts of family, community, and spirit, and we depend for our very existence on these profound contexts and connections. (1997: xv)

In many societies, disease is symbolic of the relationship between the sacred and the profane. In shamanic traditions human illness provides a bridge between these two worlds. Extraordinary states of consciousness, which are seen as mental disease in modern society, reveal sacred values to humans. Jung thought that psyche and matter were two different aspects of the same thing. With the newer unifying theories of quantum physics, such as string theory, science will probably soon be able to demonstrate how valid his ideas were. Process work differentiates between the everyday world of practical activities in which consensual views of reality reign and a more symbolic numinous realm that is governed by dreamlike events. Symptoms are seen as an attempt to compensate the one-sidedness of consensual reality and as a link to the world of sentient experiences.

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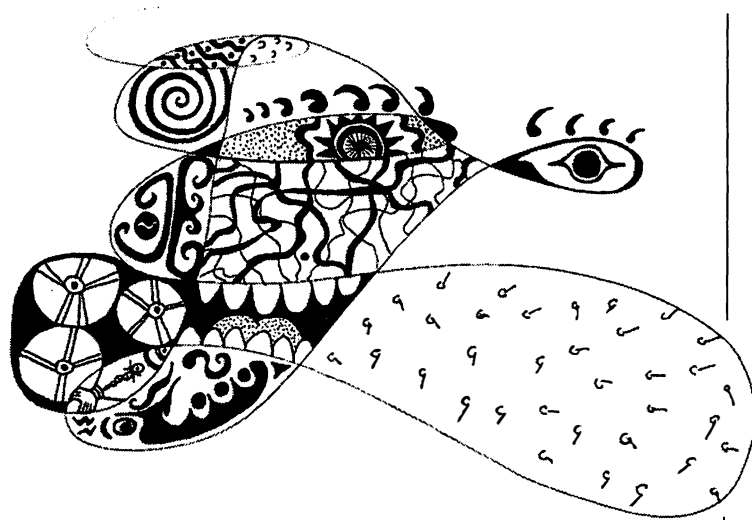
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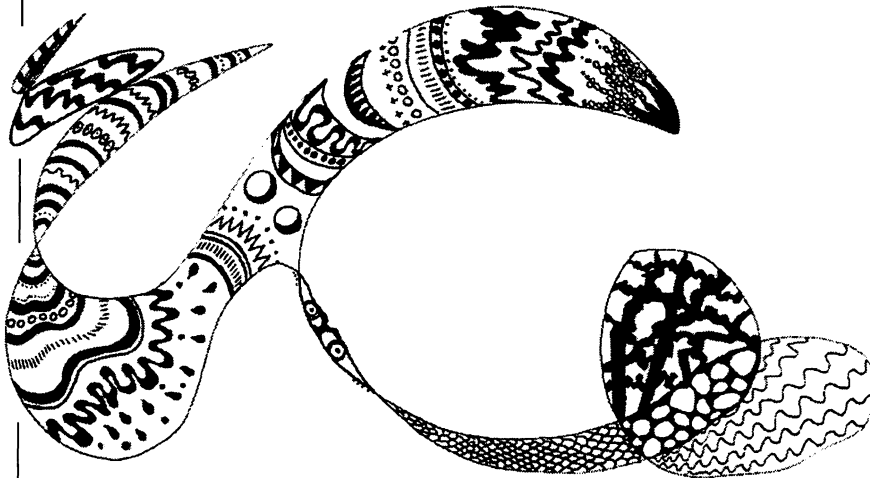
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