

PERSPECTIVE ARTICLE

From psychosomatics to somatopsychics:
A reflection and a new paradigm for ADHDRichard Fry* 

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Abstract

“Psychosomatics” may be an outdated concept if it is seen as psychological factors or states leading to physical manifestations. Rather, it is proposed, “somatopsychics” may better encompass the bi-directional nature of the inter-relationships between physical and mental health states. The field has perhaps not paid enough attention to date to the now well-established links between metabolic and mental states such as gut health. The author proposes that one example of such a state might be attention deficit hyperactivity disorder (ADHD), and its related phenomena, based on his professional journey over some 40 years of practice. He now practices as an “Integrative Psychiatrist.”

Keywords: Psychosomatics; Integrative psychiatry; Attention deficit hyperactivity disorder; Autism

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There is no inherent mystery about psychosomatics. We manifest illness in combination with mental events. However, this does require some thought about the definition of illness and the experiences we term mental events. Perhaps it will be better to say our bodies express our emotional states, which is a statement of the obvious. Who has not experienced trembling in stressful events or excitement? We dismiss that by saying it is just “sympathetic arousal” and for many years much time was focused on the role of the autonomic nervous system and cortisol in, for example, depression, ultimately with not much success.¹

The quest over the years for single events or causes leading to single conditions or illness complexes has waned as we understand more about crosslinking and multiple factors leading to particular outcomes. Now we do not need to presume A leading to B: we are able to understand more about the interaction of predisposition (genetics), precipitating (stressors and epigenetic factors), and perpetuation (social stressors, environments, toxic loads, *etc.*).²

My own journey has mirrored that route. I began in General Practice training, moved to Psychiatry, became convinced of the need to move away from simple-minded drug-based approaches to mental illness, took up individual and then family/systemic modes of thought with alacrity, and then met reality. Reality demands that you make a difference to people’s lives and problems consistently and humanely. It also requires that you look at evidence but view it critically and from an informed base. Finally, it needs you to understand the statistical and numerical manipulations employed to justify the proposed findings. I do not think that many of us really fully comprehend the statistical

methods employed in many studies these days, rather we accept the statistics without understanding the methods behind them, and thus their validity.^{3,4} I also think that the reliance on group and cohort based studies which cannot and deliberately do not take individual variation into account is misguided. This is where genetic groupings would be helpful.

Hence, after many years of practice, I started to integrate my medical knowledge, my research experiences, and my psychiatric time into a whole. The idea that all mental illness is either socially (environmentally) driven or physically based (but in ways not understood) seemed exclusive and unhelpful. My old Professor at St George's with whom I worked for a number of years – Arthur Crisp – was fond of the “biopsychosocial” model for years before it trended.⁵ However, I noted from early that much more emphasis was laid on the first two and less on the social. I might now term that “environmental” and look for those factors in the genesis of the conditions I now see.

I no longer practice as a psychiatrist foregrounding my dynamic or family (psycho) therapy skills. I was never one who enjoyed the prospect of placing my (increasingly child) patients on psychoactive drugs but the tide has been against me in the past 25 or so years. The usage of selective serotonin reuptake inhibitors (SSRIs) in children is now common,⁶ and stimulants. We will come to those shortly. Moreover I, along with colleagues, now use these daily. The previous abhorrence of the idea when I was training 50 years ago that a child might take a medicine rather than have psychotherapy in Child Guidance Services, leading to prolonged therapy that often went nowhere, has evaporated. Or has it? The new orthodoxy is that children must have received cognitive behavior therapy (CBT) before medication, or with it.⁷ Dynamic psychotherapy has given way to CBT that also often goes nowhere, but at least is shorter. Medication is now legion.

Hence, how are these issues tied up with psychosomatics, an area of interest and the focus of my research over the years? Well, diseases and trends come and go, and currently, attention deficit hyperactivity disorder (ADHD) and autism spectrum are having their moment. In my world ten or even five years ago very few people turned up with these as presenting questions of diagnosis. It was emotional difficulties, anxiety, behavioral (oppositional) disorders, occasionally, poor school attainment, or depression (covert). Now they come with little else. I see it as my role to help understand the complexity of such presentations and not give simplistic labels to complex disorders. This gets me into trouble, because the social pressure and flow now is to get a diagnosis of ADHD and medicate it.⁸

I see ADHD as a psychosomatic disorder *par excellence*. It is a physically defined condition in terms of the motor hyperactivity (hyperactive subtype), restless fidgeting and fiddling are frequent and the subjective sense of a busy or overcrowded brain are also common features. These and the inability to concentrate are not dissimilar to pain, and the literature on pain and its psychosomatic links is voluminous. In addition, it is now part of my approach to try to delineate the causative factors leading to this distressing condition, not simply label it and treat with medicines. In the end, all conditions are “psychosomatic”, or biopsychosocial (as Prof. Crisp would have had it), or multi-factorial as I would have it. Of course, there are some conditions that have more of one thing than another – retinoblastoma is one such – but even there epigenetics might be argued to play a part.

The traditional view of psychosomatic illness would only look at an evidently physical endpoint and ask how mental phenomena were involved in creating or expressing that condition. The more inclusive approach would ask how a problem that we label as an illness was related to constitution, experiences, and lifestyle and by implication how the condition fed back into and influenced those to create perpetuation. That is what I do most days with “ADHD”, autism spectrum, and all the other presentations I see. I am not alone but we are still rather few.⁹

I have recently started to talk about how “ADHD” is like bread. There are many types of “bread” and some have ingredients that some people might query as falling into the bread category. Polish potato bread is one. How do we decide if it is “bread”? We can set up a bread committee: they are expert bakers and manufacturers so we will ask them to decide. The DSM committee (for it is they) decide that this cluster of things is indeed (bread) ADHD and *hey presto!* there it is, defined and the eligible ingredients listed in a checklist. However, bread is composed of many different things so it may make sense to look at what got us here. Moreover, bread is pretty good with butter (or, as shall call it, methylphenidate). However, perhaps not all breads are good with butter; maybe olive oil is better?

Thus, I now spend my time trying to determine what makes this person unable to concentrate for long enough, fidget, or unable to initiate organized tasks. That is, determine the physical or constitutional contributors to a manifest condition that is currently listed in the Psychiatric chapter of the DSM. Have you noticed how things get put in that category until a “real” cause is found and they then become the province of physicians?

Perhaps that is why I continue to struggle with this. I am not one or the other – not a (now ex) GP, or a pure

Psychiatrist – but someone who has never really believed in the duality of mind and body. A psychosomaticist, or as I now term it, an Integrative Psychiatrist. The irony for me is that having started as someone who saw only psychological/psychodynamic solutions to psychiatric illness and veered away from physical treatments, I now see physical factors, genetics, toxic loads, biome imbalance, and dietary adequacy as some of the root contributors to mental and psychiatric “disorders”. This does not prevent me buttering the bread with medication on many occasions but it does make me respect the ingredients and flex the butter choice depending on the components. It may also make me suggest a variation in the recipe.

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