PSYCHOSOMATIC DISORDERS IN ADOLESCENTS

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Abstract: Psychotherapy of psychosomatic disorders in adolescents is one of the most responsible tasks a therapist could undertake. The psychosomatic spectrum of disorders in children aged between 5 and 18 years is widespread. The similarity between the various symptoms lies in the fact that they are masked gratified desires, but not in an adequate but neurotic manner. Psychotherapy should be approached individually and the personality traits and characteristics of adolescents should be taken into account. This article looks at some of the most common disorders and the causes of them. The focus is not on eliminating the symptom, but on the cause of it. Many clients have serious difficulties in understanding the full dynamics of a psychosocial syndrome. Psychosomatic disorders belong to a larger group known as psychogenic diseases, which can generally be considered as physical diseases caused or modified by the brain for purely psychological reasons. Psychosomatic pain is often due to hidden emotions. Grief, stress, and anxiety can all occur physically. If the patient has recently had a traumatic experience, this may give the therapist an idea of where these symptoms originate. Other times, the root of the problem may be less obvious. People who have experienced deep emotional trauma in the past may have buried those emotions, which would be expressed through physical pain years, even decades later. A remnant of anger and rage from childhood that has never been expressed can be a serious cause of a psychosomatic symptom or illness. For example sexual, physical or emotional abuse, parental problems, including alcoholism, depression, anxiety, drug addiction, psychosis, unrealistic parental expectations of the child, social tension, and others resulting from self-imposed tension (i.e. internal conflict), stress and tension from everyday life. Let us not forget that psychosomatic manifestations, in the form of physical symptoms, can be a protective mechanism of the brain. The brain diverts attention to the body to prevent the awareness of confrontation of some unconscious, repressed or threatening feelings, in particular anger/rage. Once the individual accepts this explanation and is aware of the brain's strategy for diverting attention from emotions to the body, the physical symptoms may disappear. Often there is no medical explanation for the symptoms - there is a pain but no evidence of illness. Symptoms begin when a person reaches their physical and emotional limits. This limit is specific to each person. Psychoanalysts speak of a psychosomatic personality type. Psychosomatic disorder is a way of coping with illness. Symptoms are an indicator of an overall imbalance and a need for personality harmonization.
Keywords: psychotherapy, psychosomatic disorders, adolescents, symptom

1. INTRODUCTION

Psychotherapy for psychosomatic disorders is a responsible process and, in most cases, works with the painful awareness of the fact that one is a bearer of self-destructive memories, intentions, traits, and this creates anxiety. The desire is to rescue her acts as a motive for pushing out painful information. This ejected information, as well as the past ejection process, is unconscious, but for all of them, there is inherent evidence to support their real existence. The leading part of this evidence is "uninvited, unsympathetic guests," which Freud called "symptoms." The task of psychoanalysis and psychotherapy is to disclose specific manifestations of the relationship: repulsive craving information - its specific conscious manifestations (symptoms).

2. PSYCHOSOMATIC DISORDERS IN ADOLESCENTS

In adolescents, unmet desire creates frustration with an even greater magnitude than in adults, and as a result, the child feels helpless and powerless. The natural emotional response to a blocked or thwarted desire is the appearance of anger as a satisfactory relief of the frustration process. Anger is the only tool through which the adolescent can regain his "power" over the situation (Kurt, 1982).

In many cases, for one reason or another, it is difficult to express the range of emotions being tested because the nature of the anger is of the "caliber" of the attacking emotions. When suppressed, along with the desire, it attaches itself to the Self and simultaneously attacks it. The expressed symptomatology is the result of the attack on the self-image (Gardner et al, 2007).

In the human psyche, no desire is denied: if it is impossible to fulfill and fulfill the parameters desired by the self, it is fulfilled in the form of psychosomatic symptomatology. The paradox is that it is difficult for a person to part with even some of the most painful symptoms because they are actually his satisfied needs. Because of the anger suppression process described above, and because the symptom that emerges afterward is a satisfied desire, rules are outlined for anger and symptoms that indicate the following points (Gergely&Watson, 1996).

• Where there is anger suppressed, along with the suppressed desire, not only will there be symptoms, it must have symptoms;
• Where there is no anger and repressed desire, not only will there be no symptom, but there can be no symptom;
• Where there is a symptom, not only will there be repressed anger along with repressed desire, but there must be repressed anger with repressed desire;
• Where there is no symptom, not only will there not be repressed anger and repressed desire, but there can be no repressed anger and repressed desire (Singer, 1979).

Despite the individual approach to each case of psychosomatic manifestation in adolescents, the common thing between them is the cause of the anger that lies behind the question "who?". In some cases, when the answer to "who?" In the human equivalent is absent, then the target of this anger becomes the Self. This autoaggressive response gives birth to psychosomatics (Kubzansky, 2016).

In identifying the target of anger and then becoming aware of that emotion, then the anger disappears more easily in the process of psychotherapy. This process takes place by including anger in the "active doing and happening of something" associated with the original desire. These actions accelerate the deletion of the symptom. Man's active participation puts him "in front of the line" - in a real place, outside that space "behind the line" - ie. beyond the withdrawal in which the symptoms of the psychosomatic spectrum reside (Fosha, 2000).

When the symptom is the result of implosion due to anger directed at the Self and given the high levels of magnitude, intensity, penetration, and chronicity of this anger, the maximum irradiation of the psyche implies overcoming the symptom by adding medication (Frijda, 2009).

3. SYMPTOMS AND METHODOLOGIES

The anxiety caused by this whole process is a symptom in itself. Alarms are specifically experienced in adolescents. The above contingent is between 5-18 years. deliberately avoids talking about the painful and repulsive topics that are the root of the angry and anxious reaction. In the psychotherapy room, the client performs a verbal account of the anxiety experienced. Verbalizing one's emotion, one is verbally "poor" from experience, even from facts, because of an unconscious desire to suppress rising anxiety (Carr, 1989).

My psychotherapy practice has shown a straightforward link between personal anxiety and the manifestation of verbal and physical aggression. The personality rebels against anxiety and this forces her to include aggressive behaviors in her behavioral repertoire. Consequently, the registration of such forms by the psychotherapist should be regarded as a sign of an unconscious interest in the dulling of anxiety at the root of which repressed precursors are based. All my hypotheses about the above were confirmed on the basis of a study of 150 adolescents between 5 and 18 years of age. to which the following methodologies were applied:

- Spielberger Self-Assessment Scale;
- Buss-Durkee aggressiveness test.

After applying correlation analysis between levels of personality anxiety and verbal aggression and personality anxiety and bodily aggression, a proportional relationship was established in both directions. After analyzing the results of the applied statistical procedure, using the SPSS software, we found a significant, strong proportional relationship between personality anxiety and the manifestation of verbal aggression (r = 0,585; sig <0.001) and a proportional dependence with the presence of a strong and significant relationship again. between personality anxiety and physical aggression in 150 adolescents undergoing psychotherapy (r = 0.586; sig <0.001), "r" is the correlation coefficient and "sig" determines the significance of the correlation. The results obtained are a contribution to the work of the psychotherapist because of their statistical significance, relevant to the whole population, and not just to the sample (Sig <0.005) (Dimitrova, 2020).

The available psychosomatic symptoms, based on the results discussed so far, include a wide range of disorders, including those of "implosive" nature such as schizophrenia, personality cleavage, affective and depressive disorders (Bankova, 2015).

In adolescent psychotherapy, a deep connection has been found between traumatic childhood experiences and present behavioral manifestations in the form of clear symptoms. The process involved a family psychotherapy intervention, with work from 10 families continuing to this day (Seligman, 2015).

Going through the emotional equivalents of the three interaction stages:
1. Connectivity;
2. Identification;
3. Separation,

In many of the studied cases, after conducting a primary psychotherapy interview, the presence of auto-aggressive manifestations was detected, with the most common form of auto-aggression being the depressive state (Seligman, 2017).

4. CONCLUSION

Regardless of the type of symptom and its magnitude, the dilution of the accumulated tension occurs through the passage of 4 basic steps to peace of mind, the key of which is to establish the origin of the anger. The follow-up process is individual for each client, but the work of the therapist is more focused and aimed at eliminating NOT the symptom but the cause of its occurrence, which is the main task of the psychotherapeutic process.

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