

Typical Psychosomatic Problems in Children's and Adolescents' Development

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Abstract

Psychotherapy of psychosomatic disorders in adolescents is one of the most responsible tasks that a therapist could take on. The psychosomatic spectrum of disorders in children aged 5 to 18 is wide-ranging. The similarity between the individual symptoms lies in the fact that they are masked satisfied desires, but not in an adequate, but in a neurotic way. Psychotherapy of psychosomatic disorders is a responsible process and in most cases works with the painful awareness of the fact that a person is a carrier of self-deprecating memories, intentions, and traits, and this gives rise to anxiety. The desire to be saved from it takes on the role of a motive for pushing out the painful information. The process of psychotherapy should be approached individually and the personal characteristics and character traits of adolescents should be taken into account. This article examines some of the most common disorders, as well as the causes that caused them. The focus is on eliminating not the symptom, but the cause of its occurrence.

Keywords: psychosomatics, children, adolescents.

1. Introduction

Psychotherapy of psychosomatic disorders is a responsible process and in most cases works with the painful awareness of the fact that a person is a carrier of self-deprecating memories, intentions, and traits, and this gives rise to anxiety.

The desire to be saved from it acts as a motive for repressing the painful information. This repressed information, as well as the process of repression that has taken place, have an unconscious nature, but all of them have inherent evidence confirming their real existence. The task of psychoanalysis and psychotherapy is to reveal specific manifestations of the relationship: repressed painful information – its specific conscious manifestations (symptoms).

In adolescents, unsatisfied desire generates frustration of even greater magnitude than in adults, and as a result the child feels helpless and powerless (Cobb, 1974). The natural emotional response to a blocked or thwarted desire is the emergence of anger as a pleasurable relief from the frustration process.

Anger is the only tool through which the adolescent can regain “power” over the situation. In many cases, for one reason or another, it is difficult to express the spectrum of emotions experienced, because the nature of anger is of the “caliber’s range” of attacking emotions. When repressed, along with desire, it attaches itself to the ego and simultaneously attacks it. The expressed symptomatology is the result of the attack on the ego.

2. Methods

In my psychotherapy practice, for the past 9 years, I have worked with hundreds of children with psychosomatic symptoms, coming from disharmonious families (families with dominant only primary or only secondary abilities; with the inability to integrate a balance between them in the conceptual framework of the family environment). My observations date back to January 2016 up to date.

Despite the individual approach to each case of psychosomatic manifestation in adolescents, what they have in common is the reason for the appearance of anger, which lies behind the question “who” (Jores, 1981).

In some cases, when the answer to “who?” in human equivalent is absent, then the target of this anger becomes the Ego. This auto-aggressive response gives rise to psychosomatics. By identifying the target of anger and then becoming aware of this emotion, anger disappears more easily in the process of psychotherapy. This process occurs by involving anger in “actively doing and happening something” related to the original desire (Gieler, 1987).

These actions accelerate the elimination of the symptom. The person’s active participation places them “ahead of the line” – in a real place, outside that space “behind the line” - i.e. outside that withdrawal in which the symptoms of the psychosomatic spectrum reside. My psychotherapeutic practice testifies to a direct proportional relationship between personal anxiety and the manifestation of verbal and physical aggression. The personality rebels against anxiety and this forces it to include aggressive forms of behavior in its behavioral repertoire. Therefore, the registration of such forms by the psychotherapist should be evaluated as a sign of an unconscious interest in dulling anxiety, the basis of which are repressed predecessors.

3. Results

All my hypotheses regarding the above were confirmed based on the study of 150 adolescents between 5 and 18 years of age, to whom the following methods were applied:

- Spielberger Self-Assessment Anxiety Scale;
- Buss-Durkey Aggression Test.

After applying a correlation analysis between the levels of personal anxiety and verbal aggression and personal anxiety and physical aggression, a proportional relationship was established in both directions. After analyzing the results of the applied statistical procedure, using SPSS software, it was found that there is a significant, strong proportional relationship between personal anxiety and the manifestation of verbal aggression ($r=0.585$; $\text{sig}<0.001$) and a directly proportional relationship with the presence of a strong and significant relationship between personal anxiety and manifestation of physical aggression in the studied 150 adolescents undergoing a psychotherapeutic process ($r=0.586$; $\text{sig}<0.001$), where “ r ” is a correlation coefficient, and “ sig ” determines the significance of the correlation. The results obtained are a contribution to the work of the psychotherapist, due to their statistical significance, relative to the entire population, and not just to the specific sample ($\text{Sig}<0.005$).

The available psychosomatic symptomatology, on the basis of which the results discussed so far were derived, includes a wide range of disorders, including those of an “implosive” nature, such as schizophrenia, split personality, affective and depressive disorders. In psychotherapy with adolescents, a deep connection was established between traumatic childhood experiences and current behavioral manifestations in the form of clearly expressed symptoms. The process included family psychotherapeutic intervention, and work with 10 of the families continues to this day.

Moving through the emotional equivalents of the three interaction stages:

- (1) Bonding;
- (2) Identification;
- (3) Separation.

And most importantly, focusing on SEPARATION, not SEPARATION at all, reduces parental anxiety and allows for further work by the therapist on delegating autonomy to adolescents, which precedes the formation of responsibility as a key personality trait.

In many of the studied cases, after conducting an initial psychotherapeutic interview, the presence of auto-aggressive manifestations was identified, with the most common form of auto-aggression being a depressive state.

Regardless of the type of symptom and its magnitude, the release of accumulated tension occurs by taking 4 basic steps towards peace of mind, the key of which is identifying the origin of the anger.

4. Discussion

The paradox is that a person finds it difficult to part with even some of the most painful symptoms, because they are actually his satisfied needs (Benedetii, 1983). Due to the above-described process of suppressing anger and the fact that the symptom that appears afterwards represents a satisfied desire, rules are formed regarding anger and symptoms, which indicate the following points:

- Where there is suppressed anger, along with suppressed desire, not only will there be symptoms, there must be symptoms;
- Where there is no suppressed anger and suppressed desire, not only will there be no symptom, there cannot be any symptom;
- Where there is a symptom, not only will there be suppressed anger along with suppressed desire, but there must be suppressed anger with suppressed desire;
- Where there is no symptom, not only will there not be suppressed anger and suppressed desire, but there cannot be suppressed anger and suppressed desire.

Despite the individual approach to each case of psychosomatic manifestation in adolescents, what they have in common is the reason for the appearance of anger, which lies behind the question “who?”. In some cases, when the answer to “who?” in human equivalent is absent, then the target of this anger becomes the Ego. This auto-aggressive response gives rise to psychosomatics. By identifying the target of anger and subsequently becoming aware of this emotion, anger then disappears more easily in the process of psychotherapy. This process occurs by incorporating anger into “actively doing and making something happen” related to the original desire. In some cases, the child finds himself in an environment that creates hostile impressions in him, which make him perceive the world as hostile to him (Kinzl, 1989). This impression is quite understandable, considering the dissatisfaction of the child's brain.

These actions accelerate the elimination of the symptom. The person's active participation places him “ahead of the line” – in a real place, outside that space “behind the line” – that is, outside that withdrawal in which the symptoms of the psychosomatic spectrum reside. The anxiety generated by this whole process is itself a symptom. Signal anxiety is experienced in a

specific way by adolescents. The above-mentioned contingent between 5-18 years of age deliberately avoids talking about the painful and repressed topics that are the roots of the angry and anxious reaction.

In the psychotherapy office, the client verbalizes the anxiety he experienced. By verbalizing his emotion, a person is verbally “poor” in terms of experiences, even facts, due to the unconscious desire to silence the rising anxiety.

My psychotherapeutic practice testifies to a direct proportional relationship between personal anxiety and the manifestation of verbal and physical aggression. The personality rebels against anxiety and this forces it to include aggressive forms of behavior in its behavioral repertoire. Therefore, the registration of such forms by the psychotherapist should be evaluated as a sign of an unconscious interest in dulling anxiety, the basis of which are repressed predecessors.

5. Conclusion

All manifestations of this kind, regardless of whether they are due to disharmony caused by excessive primacy or excessive secondaryness in the family conceptual framework, have one thing in common – the child becomes more or less isolated. Children who, for example, have psychosomatic symptoms related to the digestive system, react to food in a completely different way than children who grew up in a harmonious family environment of an integrated balance between primary and secondary abilities. Often these children do not feel part of a community, they even reject the world and others. Life does not present itself in a particularly favorable light for these adolescents. They either feel like martyrs or fighters. This is a picture of the extremes in which they were raised – excessive secondary or excessive primary.

The principles of treatment of somatic and mental illnesses at different times have been closely linked to the corresponding idea of human nature. The developing medicine of the West is the medicine of diseases: it studies the conditions for the development of a disease state, its regularities, as well as the possibilities for intervention.

A transcultural model was established at the foundation, which categorically connects the individual; family and culturally determined forms of the phenomenon and requires unity in diversity.

The cause of difficulties does not always lie in the imperfection of the organism. It is due to a large extent to the difficult tasks set by an environment that does not understand it, or to some carelessness in setting these tasks; some defect in the child's environment based on complications in the outside world.

Because the child who wants to adapt to his surroundings, in this case to feel like a full member of the family environment, even if it is disharmonious, suddenly encounters difficulties in this adaptation.

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