The butterfly in the room

Therapists need to be alert to the mental health effects of physically generated symptoms in clients, says **Geraldine Marsh**

Kay* drops into the client's chair and apologises profusely for being late. 'I'm lazy and slow' is her opening sentence. She rubs her round face and runs a handkerchief across the back of her neck. Her doctor has diagnosed depression, she says, and has suggested antidepressants, but she's already taking statins and HRT and isn't keen. Her daughter urged her to try counselling.

At the assessment, Kay lists her physical ailments on her swollen fingers - fatigue, irritable bowel syndrome, aches and pains, tiredness. I notice her looping back around, as if she's forgotten what she's told me: 'Did I mention the tiredness?' She rubs her eyes as she talks about her relationship. Her husband is sick of her not 'pulling her weight'. She's sure he's disgusted by her middle-age spread. Her libido's gone and she's scared he'll head off too, after 25 years of marriage.

At this point, she becomes emotional and I follow her need to understand the difficulties with her home life and her relationship. The session, topped by an assessment and tailed by our agreement to meet initially for eight sessions, comes to an end.

Depression. I underline the word, then draw a figure of eight, like wings. Something flickers in my peripheral vision, out of reach. Later, much later, I circle the error too.

Kay cancels the next session, apologises and sets up another. Five sessions go by and Kay is not getting any better. She becomes more confused, reiterating facts she's already told me. Worse, she is paranoid that somebody is stalking her, that people are listening in on her phone calls. We talk it through and she agrees to speak to her GP. I call my supervisor to discuss Kay and doodle figures of eight in the margins, like wings.

Missing clues

There's something I'm not understanding, some clue that I've missed. Kay's paranoia stems from somewhere, so what are the origins of this burgeoning psychosis? I talk it through again in peer supervision, trawl through training notes, and even check past presentations of other clients for clues.

Kay doesn't turn up for her next session. Her daughter, who had arranged the counselling, phones me and shares that her mother had some kind of episode in the shopping centre and security was called. The doctor re-ran some tests on her and...

I think, 'She's going to say they suspect psychosis. Paranoid schizophrenia perhaps.'

'Borderline myxoedema,' she says.

The butterfly lands. Myxoedema is caused by severe and untreated hypothyroidism, when an underactive thyroid gland does not produce enough hormones. It is rare, but still occurs. I swallow hard and rub the scar on my throat. My own butterfly-shaped thyroid gland only has one wing, following a partial thyroidectomy 20 years ago. I marvel that I'd noted my client's mental and emotional symptoms - tiredness, lack of concentration, depression and confusion - and still hadn't seen what was in front of me. Admittedly, I couldn't remember myxoedema being mentioned on my counselling training course 10 years previously, or how a case of acute hypothyroidism would present in the therapy room.

Symptoms and treatment

The thyroid is a butterfly-shaped gland at the base of the neck. Sometimes that butterfly stops (metaphorically) beating its wings - it's estimated that one in 20 people in the UK[1] have a thyroid condition that causes too little or too much thyroid hormone to be produced. Thyroid hormones play a role in the metabolism of all the body's cells. In 90% of cases of hypothyroidism - underactive thyroid production - the cause is an autoimmune condition called Hashimoto's disease.[2] Often the first confirmation comes when a patient is told they have a raised level of thyroid stimulating hormone (TSH). Common treatment in this instance would be for a doctor or endocrinologist to prescribe the patient levothyroxine, a synthetic drug that mimics a naturally occurring hormone called thyroxine, often known as T4.

I had 20 years of lived experience with Hashimoto's disease and the resulting hypothyroidism, yet I hadn't seen the clues to my client's condition that relate to my own life. I'd missed this, I thought, because my own physical symptoms are so enmeshed into my emotions, feelings and mental states - my illness is so much part of me I can't see the join.

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Mind-body loop

While myxoedema is thankfully rare, clients who have been diagnosed with a thyroid issue are often living with challenging physical symptoms that affect their mental state. For example, if thyroxine (T4) or triiodothyronine (T3) levels are low, a client may feel sluggish and fatigued and suffer brain fog and low energy. They can also feel depressed, and because physical energy is low, it can then be a struggle to function in everyday life. As a therapist, it would be easy to miss the physical symptom behind your client's anger and frustration at themselves and their manifestation of low self-esteem. In responding to a client's cascade of unhappy feelings, we could be distracted by the resultant mental health effects of what could be physically generated symptoms.

Yet, like Alice in Wonderland nibbling the mushroom, if a client takes *too much* levothyroxine, or suffers from hyperthyroidism, they can feel sweaty, shaky and have heart palpitations. Again, these physical symptoms mirror anxiety responses and can also have therapists looking for mental causes of anxiety, rather than understanding the interconnectedness of these physical symptoms and mental states. The person can experience a mind-body feedback loop that keeps them locked into anxious feelings or depressed feelings because of the physiological changes. This doesn't make anxiety any less real, just harder to separate out from the condition.

Also, because symptoms such as fatigue are generic, clients may be misdiagnosed with menopausal symptoms or depression. If there's no blood test or diagnosis that a client can point to, then how would a therapist pick up this issue at assessment? Equally, a client who has had a blood test could still suffer symptoms if their levels of TSH and T4/T3 are deemed to be within what is considered the 'normal' range in the UK, which is considerably wider than those used by other countries.

Cause and effect?

What makes the presentation of depression or anxiety even more difficult to untangle from the effects on the body is that current research also indicates that early life stressors can affect hypothalamic-pituitary-adrenal (HPA) axis regulation.[3] In other words, issues such as childhood trauma could increase a client's likelihood of developing an autoimmune disease such as Hashimoto's. However, in contradiction to this, the British Thyroid Foundation advises emotional problems in this client group can be *caused* by the fluctuation of thyroid hormone.[4]

While there is medical research that identifies psychiatric symptoms linked to thyroid imbalances,[5] this research does not detail the qualitative or subjective emotional states that clients may experience. Dayan and Panicker[6] provide a good overview of existing research, but none is generated from the psychotherapy world, so unless a client's presentation is extreme, how would a therapist pick up a potential issue? It may only be through a chance comment that they may realise their client is on levothyroxine or suffers from Hashimoto's disease.

While reading *Recovering with T3*, a memoir by Paul Robinson,[7] I was struck by the challenges he experienced in finding optimum physical and mental health through the normal medical channels. If clients are struggling to get a diagnosis and treatment from the medical profession, how will that affect the trust they put in us when they come to therapy?

Understanding needs

What do we need to be aware of, in order to better understand the issues of this client group, given that levothyroxine is the third most common medicine prescribed in the UK? As hypothyroidism is deemed a common condition, clients often receive a prescription from their GP rather than a referral to an endocrinologist, and annual medication reviews are done by telephone or by a pharmacist. These factors can mean that the client is not fully conversant with how their feelings and moods can be affected by their fluctuating T4/T3 levels or medication. This is confirmed by discussions on thyroid-related health forums,[8] where sufferers commonly describe struggling to find alleviation from a host of unresolved symptoms. Like people with chronic fatigue syndrome, clients with thyroid disorders often feel dismissed by mainstream medicine, and are left to find their own answers and support, which may include seeking therapy.

In supporting these clients, it feels vitally important to adopt a person-centred approach, to honour their unique difficulties and validate their experiences. I have thought about the questions I asked myself when ▶

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I was diagnosed, which could offer some starting points. For example, how does it feel to have your body attack itself, to have some insidious assassin that you can't see, hear or feel, destroy a part of you? Their body has let them down - do clients feel betrayed? I know this is how my disease left me feeling, as if I couldn't really trust myself, particularly when I was revving with energy one day and utterly exhausted the next. It may mean we need to work practically with a client and help them create their own personalised care plan. If they have varying energy levels, the work may involve moving around pieces of their life so that they can continue to work and invest in relationships and still maintain their health. Or it may prove beneficial to help the client find their voice, talk to their family or health professionals assertively and feel more empowered around their own recovery. It is definitely a case of one size of treatment not fitting all.

Some research suggests an element of permanence to a client's psychological state due to its biological origin.[9] If that is the case for certain clients, they may respond better to an acceptance and commitment therapy (ACT) approach - one that is focused on changing the client's relationship to their feelings. CBT has a role to play too, in allowing a client to separate out how to manage their health, rather than becoming preoccupied with it. I am aware of my own tendency to dwell on symptoms and become overly focused on my health, even if at that point, I am actually fine. I once spent four hours researching the role of vitamin D in all its bioavailable forms, because it helps optimise levothyroxine's conversion to T3.

Unlocking trauma

But there is also deeper work to explore with affected clients, as well as a need for further research within the psychotherapy community. For example, if there is a link between childhood trauma and dysfunction of the HPA axis, then does the unlocking of trauma facilitate any physical changes? What happens to the intensity of symptoms if a client is emotionally happier?

I feel there is an urgent need for current medical research to be translated and disseminated to therapists in a relatable way. Just as a perceived physical process such as polyvagal theory has been incorporated into the psychotherapy field, thereby giving therapists a way to work with clients therapeutically on a physical issue, a similar approach could be taken when explaining HPA axis and mental health connections. This knowledge could inform how we work with hypo/hyperthyroid clients in the future to improve their psychological outcomes.

And Kay? Her daughter called to let me know of her full recovery. Briefly I felt relief, then a great sadness at the thought of her struggling through those lost years of utter fatigue and misery.

I rub at the scar at the base of my neck and close my eyes. It's not Kay's image I see but my own mother's round, swollen face, her eyebrows that peter out and thinned hair, all classic hypothyroid symptoms. Yet it wasn't myxoedema my mother was diagnosed with. Nearly 50 years ago, after long, slow years of deteriorating mental and physical health, my mother was diagnosed as having paranoid schizophrenia. No blood tests were ever ordered. I was 11 years old but, even as a child, I can remember thinking that something wasn't right about that verdict. Through my early years, I had witnessed my mother struggling with fatigue and other chronic symptoms as her body shut down.

I am therefore left, a generation later, looping around figure eights, relieved that doctors picked up the condition in my client, Kay, yet at the same time, unsettled, knowing I will never be able to say for definite that my mother had suffered myxoedema. ■

** Client's name and identifiable details have been changed.*

'Just as a perceived physical process such as polyvagal theory has been incorporated into the psychotherapy field, a similar approach could be taken to explain the HPA axis and mental health'

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About the author

Geraldine Marsh MBACP is a psychodynamic counsellor working in private practice in south-east London. Her experiences of Hashimoto's disease and ongoing hypothyroidism shape her interest in working with clients on the interconnectedness of physical health with mental health.

www.blackheathcounselling.com