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EVOLUTION OF PSYCHOANALYTIC APPROACHES TO SOMATIC DISORDERS

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Initially, Freud proposed two distinctive ways of understanding somatic symptoms: the hysterical conversion and the actual neuroses models. The original conversion model posited that somatic symptoms had meaning and resulted from psychic mechanisms, whereas actual neuroses model proposed somatic symptoms had no meaning and resulted from physiological rather than psychic processes. Psychoanalytic psychosomatics has evolved much since those initial postulates. Insufficiencies in psychic processing of emotional experience has become a key problem for the understanding of somatic symptoms, and consequently supporting psychic processing has become the main technical challenge. Starting from Freud, this paper explores the evolution of explanatory models and technical approaches for the treatment of people affected by so-called 'psychosomatic' pathology. Some technical implications of these developments are discussed in relation to a case example.

KEYWORDS: CONVERSION SYMPTOMS, SOMATIC SYMPTOMS, PSYCHOSOMATICS, PSYCHOANALYSIS, SYMBOLISATION, PSYCHOTHERAPY

INTRODUCTION

Psychoanalysis has been prolific with ideas about psychosomatic relations. This is not surprising considering that Freud, a neurologist with naturalistic inspiration, strove to develop his theory of the mind in congruence with the medical and scientific knowledge of the time (Assoun, 1993).

Freudian works contain diverse ideas about psychosomatic relations. Concepts such as 'id (it)', 'drive' or 'organ speech (language)' (Freud, 1915) suggest a view of psychism as a realm emerging from organic foundations. Others, such as 'reciprocal paths of influence' (Freud, 1905) speak of a mutual determinism between psychic and organic processes, whilst concepts such as 'the plastic capacity of the unconscious to alter the body' and 'hysterical identification' (Freud, 1921) insinuate a capacity of the unconscious psychism to influence organic processes. All these

different and apparently contradictory theorisations reflect the complexity of the set of problems Freud tried to address.

Freud formulated two explanatory models for the development of somatic symptoms. The 'conversion' theory understood the somatic symptoms in Hysteria as symbolic expressions of repressed conflicts (Breuer & Freud, 1893–1895), in which the physiological discharge pathways of drives involved in such conflicts were altered, 'converting' the unconscious conflict into a plastic somatic manifestation via disfiguration and condensation.

In contrast, the somatic symptoms of 'actual neuroses' (anxiety neurosis, neurasthenia, and hypochondria) were seen as the result of altered metabolic processes, with no participation of psychic mechanisms. In this case, the somatic aspect of the sexual drive was thought to accumulate due to inadequate discharge (e.g., coitus interruptus, masturbation and abstinence) giving rise to tension in sexually invested organs and physiological functions, leading to the development of functional symptoms and alterations in sensations. In actual neuroses, more than suffering from memories of early sexual conflicts, Freud thought patients were suffering from *current* inadequate sexual habits.

This paper reviews how these models evolved over time, particularly the actual neuroses model, leading to contemporary emphasis on symbolisation and mentalisation, highlighting some theoretical and technical implications of this evolution in the light of a clinical vignette.

The problem of symbolism of somatic symptoms

Freud founded psychoanalysis on the discovery that some bodily symptoms seemed to respond to psychological rather than biomedical reasons. Hysterical conversion symptoms were seen by Freud as a disguised substitute for an unconscious conflict (Breuer & Freud, 1893–1895), equivalent to a disfigured pantomime staging a psychic conflict rejected by consciousness. Symptoms (conversion and other psychoneurotic) were seen as compromise formations replacing repressed contents in consciousness (for example, the paralysis in a leg developed after a night out dancing with a stranger might take the place of a prohibited sexual scene).

According to this theory, bodily symptoms are a symbolic representation of a prohibited wish, deformed by a compromise formation between satisfaction and rejection. The symptom usually involves an aborted expressive movement, the repression of the affect originally aroused by the conflict and its 'discharge' in the bodily symptom. The choice of bodily part or function is determined by its link to a natural pathway of expression of the repressed impulse (e.g., hips are involved in sexual motions), or to a figure of speech[1] (chest pain = 'heartache'; pain in the face = a 'slap in the face' as in a humiliation).

Conversive symptoms are still recognised in modern diagnostic systems, although with different nomenclature that reflects different explanatory models or disciplinary backgrounds, such as functional neurological disorder (APA, 2013; WHO, 2010).

Freud advised against applying psychoanalysis to medical conditions, respecting the boundaries of other medical specialities, with the hope psychoanalysis would be similarly recognised and respected in the medical field. This didn't stop others from openly applying the conversive model to interpret the meaning of most diverse organic manifestations and illnesses (Groddeck, 1923). Stekel held a similarly wide perspective with his 'somatization' concept (1924). This ample 'conversive' view of bodily or medical illnesses also had supporters closer to our times, such as McDougall who saw psychosomatic manifestations as an archaic form of hysteria with arcane symbolism, hard to decipher but meaningful nevertheless (see McDougall, 1989) and Chiozza, who proposed a return to the Freudian hypothesis of 'organ speech' to regard organic manifestations as inherently expressive, based on the principle that the organic is the way unconscious processes present themselves to our consciousness (1999).

In contrast to conversive symptoms, Freud thought that actual neuroses symptoms had … *no 'sense', no psychical meaning* (Freud, 1917 [1916–1917], p. 387). In his clinical experience somatic symptoms *do not admit to being traced back historically or symbolically to operative experiences and cannot be understood as substitutes for sexual satisfaction or as compromises between opposing instinctual impulses, as is the case with psychoneurotic symptoms* (Freud, 1912, p. 249).

Unlike psychoneuroses (Hysteria, Obsessions, etc.) in which psychic mechanisms are thought to create the symptoms, Freud regarded actual neuroses as lacking psychic complexity, referring to them as 'simple' (Freud, 1896, p. 167), 'common', 'spontaneous' or plainly as 'neurosis', in fitting with the popular idea at the time that regarded them as simple functional alterations of the nerves.

The 'actual' somatic symptoms included cardiac (tachycardia, arrhythmia, pain) and respiratory alterations (shortness of, agitation), perspiration, trembling, vertigo, sudden diarrhoea, and paraesthesia in anxiety neurosis; spinal irritation, intracranial pressure, irritation of organs, general weakness, dyspepsia with flatulence, and constipation in neurasthenia (Freud, 1895 [1894]). In the case of hypochondria, unpleasant body sensations associated to diverse organic systems are experienced with fear of them being indicative of a serious illness (Freud, 1921).

Although the nomenclature has mostly fallen into misuse, it has been noted that many of these symptomatic manifestations are now part of current descriptions of chronic fatigue syndrome (Hartocollis, 2002), post-viral syndromes[2], pain disorders, sleep disorders, and some forms of empty or affectless depression (Marty, 1990; McDougall, 1984).

The cause of these symptoms was thought to be maladaptive sexual habits of the patient, with no psychic mechanisms involved[3], habits that led to an alteration of sexual metabolism, to a toxic accumulation of organic sexual energy that manifested in these somatic symptoms.

As with conversion symptoms, this view implied the coexistence of psychism and the body as separate planes, both operating with different logics, with some level of independence from each other, but also having some pathways of interaction. In both Conversion and Actual Neurosis theories, Freud kept a dualist position,

insinuating different types of psychosomatic or somatopsychic relationships with either biologistic or psychologistic accents.

Freud's idea that somatic symptoms from actual neuroses were caused by harmful sexual habits has not stood the test of time, but the idea that actuality and 'action' were the principal plane of life for somatising patients, in detriment of historicity, feeling and fantasising, gained prominence later on (Friedman & Rosenman, 1959; Sperling, 1968; Taylor, 1992). Pierre Marty's concepts of 'behaviour neurosis' and of 'operational life', picture patients whose existence transpire mainly in the domain of actuality, action and pragmatic operation (1990), deprived of the fantasy life and of the affectivity characteristic of neurotics.

This *negative* aspect of actual neuroses symptoms, that is, the absence of associations and fantasies, the absence of linkage of the patient's here and now with their history, in that unconscious processing dialectic by which the present gains meaning while the past is resignified, did not catch Freud's attention or curiosity[4]. Nevertheless, this negative aspect did become a prominent feature for later authors, formulated in the idea of an *impoverished psychic life*, *absence of psychic processing*, or *deficient mentalisation* correlative to somatic symptoms.

The shift from symbolism to symbolization: The start of the psychosomatic movement

Alexander's (1934) work was pivotal for the development of the psychosomatic movement. He went beyond the conversive model to study the presence of chronic emotional conflicts in a series of illnesses and functional disorders, postulating that even though not symbolically represented in the symptoms, these conflicts were responsible for the activation of physiological processes that determined the symptoms (e.g., unconscious conflicts around oral dependency provoked abnormal activation of digestive processes leading to gastric ulcer, rather than thinking that the ulcer symbolised an unconscious attack to the mother/stomach). He also developed a classification of different levels of psychosomatic pathology differentiating hysterical conversion, vegetative neuroses and psychogenic organic disorders (Alexander, 1950).

The work of Alexander and others (Deutsch, 1952; Dunbar, 1939), and the lack of conclusive evidence about the effectiveness of the 'conversive' approach, led to moderation in extreme psychogenic views, and to the exploration of alternative ways of understanding somatisation, resulting in a wider psychosomatic movement. Alexander crossed the line drawn by Freud, providing psychological explanations for physical ailments traditionally treated by medicine, but did so in a way that did not contravene the Freudian caution about conversion theory, proposing psychophysiological mechanisms whereby psychological processes arose physiological activity linked to emotions to determine organic lesions, which was in keeping with Freud's idea of actual neuroses. In so doing, he kept a dualist position, recognising two distinctive domains of existence, the psychic and the somatic, and proposing different types of relationships between these domains (see Alexander, 1950).

The classical works on *operational thinking* by Marty and de M'Uzan (1963) and on *alexithymia* by Sifneos (1973) consolidated a view that gave a central place to negative phenomena in the understanding of somatising patients, highlighting traits such as difficulties recognising and naming emotional states, an impoverished fantasy and oneiric life, a correlative type of thinking occupied with factual details of external reality, 'blank' or impersonal relationships, and a lifestyle focused on practicalities, functionality and social conformism in detriment of subjectivation.

Marty understood operational thinking and other manifestations in these patients as signs of a deficiency resulting from failures in the preconscious functioning, specifically in the articulation of thing-representations and word-representations (1990). Liberman et al. (1993) noticed a similar problem with symbolisation, describing the use of 'hollow' representations, that is, words deprived of experiential meaning, as part of the characterisation of 'over-adapted' patients, who develop a formal adjustment to external reality at the expense of internal reality. Others have drawn attention to this inverse correlation between somatisation and symbolisation (Ferro, 2009; Solano et al., 2019; Taylor, 2010).

About its origin, this deficiency in mentalisation or failure to symbolise has been attributed to an arrest in early psychic development, and also to the effects of trauma (Taylor, 2010). About the early development of the symbolisation capacity, emphasis has been made on the fundamental role that the specular or reflective function of the mother has over the infant's capacity to develop a mind of their own, in a process that entails the use of intuition and imagination to process the child's projective identifications and 'raw' sensory experience, to recognise and respond to the child's emotional needs, and their singularity as a person. With time and consistency, this leads to the infant internalising this function, constructing a mind of their own and a sense of self (Winnicott, 1967 [1999]). Maternal containment and *reverie* are seen as fundamental to support the development of the infant's mental capacity to metabolise sensory elements to form symbolic elements (Bion, 1970). Failures in the mother–child attunement can be related to different factors, being the mother's own mentalisation difficulties the most cited[5].

From the angle of affect development, the maternal mirroring process is seen as critical in the normal process of 'de-somatizing' emotional experience to turn it 'psychic' or verbal (Krystal, 1998; Schur, 1955; Taylor, 1992). Failures in this process hinder psychic differentiation of affects, leaving affect regulation entrusted to behavioural (impulsivity, hyperactivity) and somatic (eating habits, activity-rest cycles, use of substances) solutions.

The notion of difficulties in psychic processing is a nodal point connecting concepts such as emotional regulation (Taylor et al., 1997), affect differentiation (Schur, 1955), alphabetization of emotions (Ferro, 2009), emotional literacy (Steiner, 1999), mentalization (Luyten et al., 2012), preconscious work (Marty, 1990), and symbolisation, all of which refer to the process of developing psychic representations and affective manifestations, going from bodily sensations, beta elements (Bion, 1962) or pre-symbolic experience, to symbolic, verbal and conscious experiencing of emotions.

The lack of symbolic representations correlates with a reported absence or undifferentiation in affectivity that has been referred to as essential depression (Marty, 1966), states of dis-affectivization (McDougall, 1984) or 'hopelessness / helplessness' syndrome (Engel & Schmale, 1967). Similarly, a blank, formal, or impersonal relationship style (Sami-Ali, 2000) has been linked to this fantasy and emotion-less state.

In all these developments, affect has displaced sexuality as the key element not being sufficiently processed. Affectivity, just as sexuality for Freud, is seen to occupy a central place in psycho-somatic relationships, as a dual or 'hinge' phenomena with both psychological and physiological facets, where insufficient psychic processing of affective movements relates to somatic manifestation or non-regulated physiological activity.

Now, some of the previous ideas have attracted criticism. The metapsychological implications of Marty's ideas have been criticised for blurring the Freudian distinction between conscious, preconscious, and unconscious, and for neglecting a dynamic view of psychic functioning (Ulnik, 2000). Marty's characterisation of the somatic patient has been criticised as biased, self-fulfilling, as it was based on hospital patients presenting for medical care, not for psychological treatment (Cremerius, 1977). The idea of a generic inability to process affects neglects a dynamic view in which conflict and defensive dynamics determine this outcome. The shift away from childhood sexuality as a nodal point in psychopathology neglects the disruptive effect that the taboo of incest has over parents' capacity to mirror and emotionally attune to their child's sexualised behaviour (Brady, 2018).

At times complementing, at time an alternative view, some authors have underlined the role of defences as determinants of the psychic impoverishment described for psychosomatic patients. Mitscherlich (1968) used the Freudian concept of biphasic repression to explain the outbreak of somatic illness. A failure of defence, with irruption of emotional or somatic distress (Yasky et al., 2013) has also been noted. Sami-Ali proposes the massive repression of the imaginary function (Sami-Ali, 2000) as an explanation, defence that reaches both conscious thinking and oneiric life. Dejours highlighted the predominance of suppression in somatic patients (Dejours, 1989). The role of an ego ideal pointing to conformism, social adjustment, and performance has been highlighted in these defensive dynamics (Liberman et al., 1993; Maldavsky, 1992; Marty, 1990; McDougall, 1974; Sami-Ali, 1996).

Going back to the psychic processing theory, this conceptual current has operated a shift to a higher level of complexity in theorisation about psychosomatics, with the initial concern about what emotional conflicts are being symbolised by somatic manifestations giving way to questions about how is the symbolising capacity, or its failure, related to bodily processes (Greco, 1995a). Taylor (2010) succinctly conveyed this as the 'symbolism' (content level) versus 'symbolization' (process level) shift. Most of the previous theorisations assume a dualistic perspective in which psychological processes are seen as inherently intertwined with organic processes, with difficulties in symbolisation leading to the onset of somatic or organic conditions.

In her multiple code theory, Bucci (1997) integrates and expands previous psychoanalytic theorisations about types of representations and thought processing, such as Freud's Primary and Secondary Process (1915) and Bion's theory of thinking (1962), proposing three representational levels: a sub-symbolic system of representations (sensory and motor, extero and proprioceptions, congruent with Bion's beta elements), a non-verbal symbolic system (images and representations of objects, congruent with Freud's 'thing-representation' or Bion's alpha elements) and a verbal symbolic system (words and language with meaning, congruent with Bion's apparatus for thinking thoughts and Freud's 'word-representation' and secondary process) (see Bucci, 1997, 2005). Unlike Freud or Bion's postulates, it considers a sub-symbolic system of processing or 'thinking', open to learning and with capacity for sequential, organised patterns of sensory, motor activity or enactive representations (Bruner, 1966), as evidenced in complex and intelligent activity like manual crafts with fine skills, far from a 'raw' or chaotic conception of the pre or proto-psychic activity. It also proposes that these three different systems operate in parallel, linking to each other to become more complex, rather than being assimilated into each other by translation or transformation. Applied to somatization, it allows to consider a pre-symbolic sensory level of representation closer to the physical processes, from which symbolic representations (iconic and then verbal) can develop and link, expanding and clarifying the planes or systems in which these processes occur.

This theory adheres to a 'non-reductionist monism' and 'epistemological dualist' stance (Solano, 2019), where 'the mind' and 'the body' are seen not as two separate entities with a real existence independent from the observer, but following a Kantian perspective, as two distinctive ways in which we perceive the unknowable that the human being is. From this viewpoint, talking about psychosomatic relations makes no sense as there is no subordination of one domain to the other, one does not cause or determine the other: psychological and somatic processes are seen as distinctive ways of looking at human beings. As a painting can be viewed with an artistic eye, emphasising the aesthetic experience and symbolic meaning evoked in the observer, it can also be observed and analysed from a physical and pragmatic viewpoint, in which the material composition of the paint, the palette of colours and the techniques utilised in its making take centre stage. This monistic perspective has different implications for the psychosomatic field, starting with deposing the idea that thoughts 'convert' into somatic manifestations, and that there is a leap between psyche and soma, as these notions refer only to different viewpoints to conceive what goes on for human beings.

For Bucci 'affect' has a central place, as inferable phenomena equivalent to the Freudian Unconscious or the Kantian unknowable, perceptible as feelings and emotions from a psychological viewpoint, or as bodily/physiological correlates of emotions from a biological perspective.

Others (Chiozza, 1999; Solano, 2010) have pointed to a possible departure from dualism in Freud towards the end of his career when he stated psychoanalysis 'explains the supposedly somatic concomitant phenomena as being what is truly

psychical' (Freud, 1938, p. 158), phrase that can be read as a radical alignment with a biologistic perspective reducing psychic reality to epiphenomena of organic matter, or can also be read as an alignment with a monistic position, in which somatic processes are equated to how the Unconscious, the Unknowable, manifests itself to our senses, putting the psychosomatic conundrum at the heart of psychoanalytic doctrine. Bion's (1961) idea of a proto-mental matrix or system, as a necessary logical antecedent of the differentiation of psychological and physical processes points in a similar direction.

In his moment, Viktor von Weizsäcker also exposed the contradiction of founding a psychosomatic perspective on a dualistic position in which body and soul, though related, are conceived as inherently distinct and separate phenomena (Greco, 1995b). This led him to consider organic processes of health and illness as intrinsically subjective, and to propose a new medicine centred on the subject (von Weizsäcker, 1956).

Ferro (2009) steps out of these controversies, cautioning against *post hoc, propter hoc* conclusions about psychosomatic relationships based on the psychoanalytic experience. From his hermeneutic view, all we can say is that any bodily manifestation or allusions to the body observed within the psychoanalytic field should be regarded as communications awaiting to be deciphered in the context of the transference relationship. In other words, any bodily sign ('guts rumbling') or verbal allusion to a bodily process ('it guts me', 'I suffer from chronic abdominal pain') should be taken as a 'narremes' to be understood in the context of the storyline being played out in the transferential relationship, not as concrete evidence of psychosomatic relationships.

Technical implications: Body reading, emotional and relational processing

An older man came to treatment for over a year, affected by problems in his life and with the impression that early life experiences might have led him to develop prostatic cancer. His family migrated from Europe before the Second World War, and his early childhood memories included stories about relatives suffering the impact of war and Nazi persecution, and the hardships of settling in a new country with ambivalent attitudes towards Jews. When he was about four, he remembered watching his parents drive away leaving him in summer camp with the sense of being abandoned. At school, he felt weak and alienated from schoolmates, in part for being a Jew in a secular school, in part for a heart murmur that kept him away from playing and physical education. He was the second of four children and recalled with resentment his father's policy 'I'll be your friend when you become an adult, in the meantime your mother takes care of you'. His father was called to discipline him, otherwise, he was at work. His father died when the patient was 17, so early on he took care of the family business, feeling unprepared and with a sense of insufficiency, feeling he missed out on his father's love. He did not talk much about his mother, only saying she was not very expressive or affectionate. He got married to a much younger woman as it was customary for his family, and had two children,

but described the 35 years of his first marriage as unhappy, with constant fighting and 'lack of respect' from his wife. Later in life, he went through bankruptcy, which brought a lot of anxiety and grief, feeling like a failure, and losing the status that took him much effort to achieve. His divorce, bankruptcy and cancer diagnosis marked the most difficult period in his later life, falling into depression. Later he met his second wife with whom he had been together for several years.

In contrast with the life problems he reported, he presented with a cheerful and positive attitude, tending to talk through things rapidly, diverting into minor details when touching something that seemed emotionally laden. It wasn't until a few sessions into the treatment that he disclosed in passing that a recent medical exam had shown signs of a possible return of his cancer, in remission for years. During the initial phase of treatment, he avoided distressing emotions, denying feeling affected despite the painful topics he brought up and the signs he showed such as becoming teary, his eyes becoming congested, his voice deepening, and hunching over. When pointed out he brushed these signs off as mere physical niggles, either denying or minimising sadness or distress, swiftly moving to other topics. I kept drawing his attention to the links between his 'annoying' bodily signs (teary eyes, broken voice and low energy), and the concerns he was sharing about his life. His cheerful manner included the way he related to me, smiling and being amicable despite the difficult topics we touched or when disagreeing with me: he invariably presented as a good and grateful patient. I felt his attitude towards me included a mix of appreciation, admiration, fear and some resentment towards me, as if he needed to please me or risk disappointing me and provoking my anger. He seemed to invite me to keep things light, avoiding a deeper emotional connection which felt threatening. At times his stubbornly positive attitude frustrated and angered me, making me wonder how could I upset him, confirming the sense that I was a threat. He got anxious when I suggested there could be more than just pleasing and amicable feelings in our relationship, reassuring me that all was fine, as if trying to avoid a terrible situation.

I do not recall a specific turning point in this process, but gradually there was a shift from me holding these feelings for him to *him starting to talk from these feelings*. Talking about his fears eventually helped ease his defensive attitude, giving way to moments when he was able to sit more with negative feelings. Concurrently, during the second half of his treatment, his medical exams returned to normal, discarding a relapse in cancer, and his financial situation improved, which was another of his worries.

When talking about his new found feelings, he said he could not afford the luxury of being weak; getting emotional made him feel unmanly and unworthy. It went against the stoic attitude he had forged throughout his life, especially in the last few years in which he survived a life-threatening cancer, a bitter marriage rupture, and the bankruptcy of the family business he inherited from his father and that sustained his family and part of his extended family.

With much difficulty he disclosed the bitterness he felt and the regrets he felt about decisions he took such as expanding his business just before a global financial

crisis, the sense of disappointment and shame for having lost his position among successful industry peers and having to downgrade house and neighbourhood, the hopelessness he felt about the future in relation to his ageing body, fearing the loss of functions such as his memory and fearing his aches heralded a major decline. He also feared the financial uncertainty of his small factory in this new globalised world, with big corporations and open market, and felt doubts about being truly loved by his new partner and other people, fearing their love was conditional to his performance as a provider of sustenance or sexual satisfaction. He confessed the loneliness and helplessness he felt for keeping all this to himself, the resentment he felt for taking responsibility for the family business, and the bitterness of having renounced his dreams when he took over the family business at a very young age when his father died. He believed that if he did not keep his spirit up, he would collapse and never recover, become disabled, which would lead to falling into disgrace, and revert to feeling weak and incompetent as when he was a child. This reminded him of the early childhood experiences of summer camps, crying, feeling abandoned by his parents, and the weakness and shame he felt for missing them, thinking he was being childish and ungrateful to his parents who were only trying to help him grow up.

We had to interrupt the treatment after a year, but during his time in therapy his mood became sad and at times bitter but also more serious, serene, and authentic. He seemed less eager to appease and less fearful for the future. Along with these changes, his tiredness, insomnia, ocular irritation, and back pain eased, so did his fear that minor memory failures were certain indications of dementia.

This case shows an effort to restore contact with affects that were suppressed as part of a defensive character formation where stoicism and social adjustment protected from dependency and intimacy, which resonates with some of the concepts reviewed in this paper. It also shows a strategic effort to restore contact with affective movements, which included the therapist's specular function and the working through of character defences as manifest in the therapeutic relationship. I think this fragment conveys the importance of some technical emphases. I found myself containing both his rejected feelings and his need to reject them for a period of time before he could own any of them. In that sense, moderating my countertransference reactions to find the right moment, tone, and pace to reflect them back to him were key interventions in this process. At times I felt my reactions were being scrutinised to check if he was saying the right thing or if I lost interest, in a tense persecutory dynamic. The same happened when bringing up the relationship for discussion. Understanding and holding his anxieties, which translated into softening my feelings, was essential to manage the tension in these moments.

This case also shows patients presenting with somatic concern are heterogeneous, far more than characterisations in the literature suggest. Paraphrasing Otto Kernberg (2004b) it's possible that the discrepant theoretical positions here reviewed might converge more than imagined in the clinical room. Nevertheless, I believe there are some general technical recommendations that are useful when treating this cohort.

First of all, the importance of having a wide field of observation, including all behavioural and somatic manifestations, is in line with classical recommendations about character analysis (Reich, 1933) and the work with severe character pathology (Kernberg, 2004a; Yeomans et al., 2015), which is especially important when there are limitations in verbal and a predominance of non-verbal communications.

Basic psychoeducation about psycho-somatic relations might be a necessary step to help patients intellectually understand why talking about their emotional or interpersonal life might be pertinent in circumstances they are coming for a bodily ailment. Noticing and exploring the somatic sensations and concerns spontaneously brought up by the patient in the conversation, especially if the patient sees their problems as fundamentally physical, can be a good starting point, which might then lead to exploring situational and object relations associations they spontaneously make (Deutsch, 1939), including the exploration of emotional states and associated object relations pattern activated in the here and now of the therapeutic encounter. Naming the emotional movements hinted at by somatic sensations and bodily manifestations (i.e., flushing, coldness, volume of voice, gesticulation, and face expression) experienced by the patient can be helpful, being careful not to assume that the patient is aware of our emerging understanding of their own emotional world, as this gap can lead to an increase in anxiety or somatic distress when pointed out.

Keeping in mind and supporting the narcissistic equilibrium (sense of control, efficacy of their defensive efforts) of the patient is important given their possible symbolising limitations, as this determines their capacity to bear this dialogue. Cracks in this narcissistic equilibrium can also be signalled by somatic and other non-verbal behavioural signs of distress (Békei et al., 1988; Dejours, 1989).

Next to naming and making sense of somatic experience by helping the patient connect or reconnect their somatic experience with other aspects of their subjective life, it's important to work on the defensive dynamics attached to emerging experiences, which includes recognising, and validating the motivations behind defensive manoeuvres. Special consideration should be given to sudden deteriorations or decompensations during the initial stage of treatment, when we haven't worked out quite well the proper distance and pace of work with the client, as we haven't built enough common ground (associative 'neighbourhood') and familiarity with the patient to sense the impact of introducing new material. Patients with fragile defensive equilibrium or frank failure of defences might react in negative ways to seemingly 'simple' but out of touch interventions, such as pointing out a feeling they seem to be experiencing, with exacerbation of emotional or somatic distress that can lead to therapeutic ruptures or disengagement (Yasky et al., 2013). As part of the effort to regain control, these decompensations can lead to a withdrawal and narcissistic injury that can be experienced as a self-inflicted rather than recognised as an interpersonal event. When worked out, they can reveal a sense of being attacked or demanded by the therapist, showing a relational domain of primitive or faint object relations activated in the therapeutic relationship. Recognising a relational domain with its correlative emotional movements of dependence or vulnerability can be

quite challenging, reason why it's important to be responsive and build common ground.

The therapist's emotional availability and responsiveness, including at times the need to lend vitality in the encounter with the patient is part of the auxiliary role, sometimes necessary to counteract the faint presence of affective movements in the patient (D'Alvia & Maladevsky, 1996; Marty, 1995; McDougall, 1989; Sami-Alí, 2000). This refers to keeping an emotionally responsive attitude towards the patient when they might lack this same disposition in the encounter with us. More than posturing an emotional reaction it is about resisting the pull to collude into a de-affectivised interaction in circumstances this might not be reciprocated. This approach relates to Ferenczi's concern about the re-traumatising effect of an 'aseptic' therapeutic relationships (Ferenczi, 1932), which is worth remembering with patients with restricted contact with their affective world.

The management of the therapist's emotional availability to the patient highlights the fact that the containment, reverie, and reflective function the therapist exercises in the relationship with the patient is a complex unconscious process of interpersonal emotional attunement and responsiveness, involving sensory, somatic, and imagery processing, of which conscious and intellectual reflection mostly happens retrospectively. This means much unconscious interaction and processing happens synchronously during a psychotherapeutic treatment, in which the therapist's emotional involvement and role responsiveness, including somatic manifestations, are important parts of the configuration of the interpersonal field that is object of analysis.

DISCUSSION

The psychosomatic field has evolved much in the last decades. There's been an evolution in the psychoanalytic understanding of psycho-somatic relationships from seeing the soma as the stage where unconscious conflicts are symbolised, to seeing somatic manifestations as signs of a failed or disrupted process of symbolisation of 'raw' emotional experience. What remains true through this evolution is the notion of a somatic sphere of experience awaiting to be coded or decoded to create or reveal its meaning, to then become mutable subjective experience. From a technical viewpoint, the challenge has shifted from seeking to decipher the psychic meaning of somatic symptoms to supporting the process of symbolising emotional movements hinted by somatic manifestations. Either way, it's about the analyst putting their subjectivity at the service of helping the patient realise the subjective potential behind their somatic manifestations.

But developments in 'psychosomatics' extend to other fields, with neuropsychological research using imaging technology to explore how psychological processes and even psychotherapeutic change reflect on changes in neurophysiological functioning, which has brought us closer to the conviction that any psychological process, morbid or normal, is mirrored by a neurophysiological correlate, in other words, that psychological and neurophysiological change mirror each other. At an

epistemological level, different dualist and monistic propositions compete for the understanding of these psychic-somatic relationships, with a general tendency to reconstitute the lost unity of the organism, and the integrity of the human being within the world.

In the clinical field, integrative, ecological, and biopsychosocial models have become mainstream in the last decades, with the view that health and illness are complex processes comprising biological, psychological, social, and other environmental aspects. Concordantly, a multi-disciplinary approach has been adopted as benchmark for health services. Nevertheless, the definition of illness or disease still follows a biomedical model, and at a practical level, the power hierarchy still leans towards the 'bio', reflecting a materialistic bias where the body is seen as the domain in which morbid processes *really* happen, reinforcing the role of medical practitioners as the socially sanctioned administrators of health. Paradoxically, the fact that we emphasise the relationship between *different* domains (biological, psychological, social, environmental) has reinforced dualist conceptions and the idea that *these domains exist independently*. Despite constant reminders, the idea of causation keeps displacing the idea of correlation *between* domains, perpetuating the hegemony of the biomedical view.

As Greco points out, perhaps the stubbornness of dualist positions over time has to do with the fact that 'the differentiation of mind and body (or mind and matter), and the baggage of connotations associated with each of these terms, is well established empirically as a *metaphor we live by*' (Greco, 2019, p. 108, original italics). It reflects the way we think of ourselves in contemporary Western societies adhering to scientific materialism. In other words, despite abundant rational arguments, 'psychosomatics' has failed to be the anomaly that propels a scientific paradigm revolution as the dualist metaphor is still fruitful in the health field, as well as in other scientific fields connected to human productivity and lifestyle: body and mind is the ordinary and *effective* way we think ourselves in Western societies.

Seeing illness as a sign of a failed adaptation of the subject to the world, or as Freud put it, 'the cost of civilization' over the individual, is radically different to seeing it as result of a material/biological processes in which the subject has no part or only a moderating role. As Whitehead has pointed out (Whitehead et al., 2017), the bio-materialistic scientific paradigm has operated as an *ethical* liberation of the human subject whose effects are still expanding, as seen for example with the biomedical approach to mental health sparing individuals of the subjective implications of illnesses ('I have anxiety' vs. 'I'm anxious'). This critical view converges with current theorisations that stress the negative aspect of psychosomatic conditions, the absence of a subjectively troubled mind, where somatising and alienation from subjective suffering come together. This is also consistent with the emphasis placed on social adaptation, and effective operation over external reality, at the cost of neglecting the internal world. The psychoanalytic practice remains a space where 'somatic' events can be read as anomalies that signal the cost for the subject of dehumanising existence.

CONFLICT OF INTEREST STATEMENT

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ENDNOTES

1. In his idea of 'organ speech', Freud wondered whether there was an intimate phylogenetic link between development of speech, emotional movements and bodily correlates (Zepf, 2015).
2. Including long COVID.
3. At some points Freud qualified this assertion. He hypothesised that an individual could have a primary insufficiency to process sexual excitation if 'the groups of ideas to which the somatic sexual excitation should become attached are not yet enough developed' (Freud, 1895 [1894], p. 110). He also stated that a serious loss could lead to the type of over-stasis seen in actual neuroses, as the impoverished ego of the mourner has a decreased capacity to invest objects and the external world with libido (Freud, 1917 [1916–1917]). Both alternatives, underdevelopment of representations, or a narcissistic withdrawal secondary to a loss can lead to a build-up of tension (Freud, 1926 [1925], p. 138).
4. Perhaps happy to find exceptions that proved that psychoanalysis, as any scientific field, has limits and is not guilty of omniscience.
5. Description of maternal failures include 'bouncing back' the child's unprocessed anxiety, and a 'bomb-inserting' dynamic whereby the maternal object not only deflects back the child's unprocessed anxiety but adds her own unmetabolized anxiety (Liberman et al., 1993). Another failure refers to the maternal object mistranslating the infant's needs according to culturally adequate stereotypical behavioural patterns, leading to the internalisation of compulsive aspect of the mother's superego more than an empathic reflection of their own subjectivity (Sami-Ali, 1996). From a critical perspective, these theorisations might reflect the assumption that what is observed in the therapeutic relationship replicates early mother-infant dynamics.

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QUESTIONNAIRE
C1(26) Part 1 of 2
Evolution of psychoanalytic approaches to somatic disorders

INSTRUCTIONS

- Read through the article and answer the multiple-choice questions provided below.
- There is only **ONE** correct answer to all questions.

Freud's Initial Dualistic Models (Conversion and Actual Neuroses)

Question 1: *Freud's* concept of 'reciprocal paths of influence' suggests which idea regarding psychic and organic processes?

- **A:** Psychic processes always determine organic outcomes
- **B:** Organic processes are the sole cause of psychic illness
- **C:** A mutual determinism between psychic and organic processes
- **D:** The unconscious has no capacity to influence the body

Question 2: In Freud's original 'conversion' theory, how were the somatic symptoms in hysteria understood?

- **A:** As the result of purely physiological discharge pathways
- **B:** As symbolic expressions of repressed conflicts
- **C:** As symptoms lacking any psychical meaning
- **D:** As signs of current inadequate sexual habits

Question 3: According to Freud, the somatic symptoms of 'actual neuroses' were seen as the result of altered metabolic processes with no participation of which type of mechanism?

- **A:** Symbolic
- **B:** Physiological
- **C:** Psychic
- **D:** Conversion

Question 4: TRUE/FALSE: Freud's original actual neuroses model proposed that patients were suffering from memories of early sexual conflicts, similar to psychoneuroses?

- **A:** TRUE
- **B:** FALSE

Question 5: For *Freud*, the choice of a specific bodily part for a conversion symptom is determined by its link to which one of the following?

- **A:** A randomly selected organ
- **B:** Its proximity to the head
- **C:** The most recent physical injury
- **D:** A natural pathway of expression of the repressed impulse, or a figure of speech

Question 6: In contrast to conversive symptoms, *Freud* thought that actual neuroses symptoms had what characteristic?

- **A:** A complex, disguised symbolic meaning
- **B:** No 'sense', no psychical meaning
- **C:** A clear, decipherable arcane symbolism
- **D:** A link to repressed childhood traumas

Question 7: Which contemporary syndromes have been noted to include many of the symptomatic manifestations previously described under the nomenclature of actual neuroses?

- **A:** Chronic fatigue syndrome, post-viral syndromes, and some forms of empty depression
- **B:** Schizophrenia and bipolar disorder
- **C:** Conversion disorder and somatic symptom disorder
- **D:** Obsessive-compulsive disorder and generalised anxiety disorder

The Shift: From Symbolism to Symbolization

Question 8: What is the defining trait of Pierre Marty's concept of 'operational life'?

- **A:** An existence transpiring mainly in the domain of actuality, action and pragmatic operation
- **B:** An overabundance of fantasy life and affectivity
- **C:** A profound preoccupation with historical details
- **D:** A preoccupation with the symbolism of the body

Question 9: *Alexander* (1934) proposed that chronic emotional conflicts, even when not symbolized in physical symptoms, caused the onset of illness by activating …….?

- **A:** Psychotic defence mechanisms
- **B:** Early sexual traumas
- **C:** Acute infectious diseases
- **D:** Physiological processes that determined the symptoms

Question 10: The classical works by Marty and *de M'Uzan* (1963) and *Sifneos* (1973) consolidated a view of somatising patients by giving a central place to what kind of phenomena?

- **A:** Positive
- **B:** Biological
- **C:** Negative
- **D:** Social

Question 11: Marty understood operational thinking as signs of a deficiency resulting from failures in which specific type of functioning?

- **A:** Superego functioning
- **B:** Preconscious functioning
- **C:** Id functioning
- **D:** Primary process thinking

Question 12: The capacity for a child to develop a mind of their own and a sense of self depends fundamentally on the role of the mother's function, described as ……..?

- **A:** Authoritative and disciplinarian
- **B:** Dualistic
- **C:** Enforcing social conformism
- **D:** Specular or reflective

Symbolization, Affect and Defense

Question 13: TRUE/FALSE: The mother's mentalization difficulties are the least cited factor related to failures in mother-child attunement?

- **A:** TRUE
- **B:** FALSE

Question 14: Following the emergence of the psychosomatic movement and new concepts on symbolization failure, which element displaced sexuality as the primary key element not being sufficiently processed in psycho-somatic relationships?

- **A:** Drive
- **B:** Ego
- **C:** Trauma
- **D:** Affect

Question 15: What has been highlighted in defensive dynamics, pointing to conformism, social adjustment and performance?

- **A:** The Oedipus complex
- **B:** The pleasure principle
- **C:** The concept of transference
- **D:** The role of an ego ideal

THE END

QUESTIONNAIRE
C1(26) Part 2 of 2
Evolution of psychoanalytic approaches to somatic disorders

INSTRUCTIONS

- Read through the article and answer the multiple-choice questions provided below.
- There is only ONE correct answer to all questions.

Question 1: The shift in psychoanalytic theorisation about psychosomatics, as succinctly conveyed by *Taylor* (2010), moved from 'symbolism' (content level) to which other term (process level)?

- **A:** Somatisation
- **B:** Affectivity
- **C:** Symbolisation
- **D:** Conversion

Contemporary Theory and Technical Frame

Question 2: Bucci's Multiple Code Theory proposes three representational levels. Which system is congruent with Bion's beta elements?

- **A:** A verbal symbolic system
- **B:** A non-verbal symbolic system
- **C:** A sub-symbolic system of representations
- **D:** The secondary process

Question 3: In the monistic perspective, following a Kantian view, how are 'the mind' and 'the body' viewed?

- **A:** As two separate entities with real, independent existence
- **B:** As subordinate domains where one causes the other
- **C:** As two distinctive ways in which we perceive the unknowable that the human being is
- **D:** As concepts that have no utility in the clinical room

Question 4: From a hermeneutic view, how should any bodily manifestation or allusion to the body observed within the psychoanalytic field be regarded, according to Ferro?

- **A:** As concrete evidence of a psychosomatic relationship
- **B:** As communications awaiting to be deciphered in the context of the transference relationship
- **C:** As an actual neurosis symptom with no psychic meaning
- **D:** As primary process thinking needing immediate translation

Case Vignette: Clinical Application of Psychodynamic Theory

Question 5: The patient in the case vignette presented for treatment with which primary concern?

- **A:** Problems in his life and the impression that early life experiences might have led him to develop prostatic cancer
- **B:** Severe depression following his first divorce
- **C:** An intense fear of relapse following his bankruptcy
- **D:** Insomnia and ocular irritation

Question 6: What was a key characteristic of the patient's presentation?

- **A:** A reserved and hostile attitude
- **B:** A cheerful and positive attitude
- **C:** Intense emotional outbursts and crying
- **D:** Excessive focus on his bodily symptoms

Question 7: When the therapist in later sessions pointed out his bodily signs (teary eyes, low energy) and linked them to his concerns, how did the patient initially respond?

- **A:** He brushed these signs off as mere physical niggles, denying or minimising distress
- **B:** He gratefully accepted the interpretation and began to cry
- **C:** He insisted that the therapist was misunderstanding his feelings
- **D:** He immediately recognized the defence mechanism of suppression

Question 8: What fear did the patient disclose that drove his stoic attitude and need to keep his spirit up?

- **A:** The fear of being unloved by his new partner
- **B:** The fear that he would collapse, revert to feeling weak and incompetent, and never recover if he allowed himself to be weak
- **C:** The fear of his prostate cancer returning
- **D:** The fear of having to rebuild his family business again

Question 9: What change occurred in the patient's mood during his time in therapy, after which his psychosomatic symptoms eased?

- **A:** It became intensely agitated and anxious
- **B:** It became sad and at times bitter but also more serious, serene, and authentic
- **C:** It remained cheerfully positive, and less manic
- **D:** He achieved complete emotional detachment

Question 10: What was a key intervention the therapist felt was essential to manage the tension when the patient's anxieties translated into a tense persecutory dynamic?

- **A:** Firmly confronting the patient's denial
- **B:** Immediately withdrawing the intervention
- **C:** Understanding and holding his anxieties, which translated into softening the therapist's own feelings
- **D:** Directly interpreting the early childhood trauma

Technical Recommendations and Conclusion

Question 11: When working with patients presenting with bodily ailments, what might be a necessary initial step to help them intellectually understand the relevance of talking about their emotional or interpersonal life?

- **A:** Delve into their deepest unconscious conflicts
- **B:** Focus exclusively on their physical symptoms
- **C:** Set a strict time limit on somatic complaints
- **D:** Provide basic psychoeducation about psycho-somatic relations

Question 12: When naming and making sense of somatic experience, the therapist must be careful not to assume the patient is aware of the therapist's emerging understanding of their emotional world, as this gap can lead to ……..?

- **A:** An increase in anxiety or somatic distress
- **B:** A "premature" resolution of the somatic symptoms
- **C:** An immediate shift to transference work
- **D:** An unfounded sense of relief and gratitude

Question 13: TRUE/FALSE: The therapist's role responsiveness should aim to pull the patient into a de-affectivised interaction to match the patient's disposition?

- **A:** TRUE
- **B:** FALSE

Question 14: Despite the shift in psychoanalytic understanding over time, what remains true about the somatic sphere of experience?

- **A:** It is always a definitive, literal representation of an unconscious conflict
- **B:** It has no connection to subjective experience or meaning
- **C:** It is a sphere of experience awaiting to be coded or decoded to create or reveal its meaning
- **D:** It must be disregarded in favour of focusing on verbal symptoms

Question 15: What is the main technical challenge that has emerged from the evolution of psychoanalytic psychosomatics?

- **A:** Deciphering the symbolic meaning of somatic symptoms
- **B:** Applying the hysterical conversion model
- **C:** Treating actual neuroses with medication
- **D:** Supporting psychic processing/the process of symbolising emotional movements

THE END

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ANSWER SHEET

C1(26)

Evolution of psychoanalytic approaches to somatic disorders

***Time spent on activity** **hour** **min**

You can complete any one, or all the parts of this activity.

PART 1												PART 2											
	A	B	C	D	E		A	B	C	D	E		A	B	C	D	E		A	B	C	D	E
1						8						1						8					
2						9						2						9					
3						10						3						10					
4						11						4						11					
5						12						5						12					
6						13						6						13					
7						14						7						14					
						15												15					

How relevant was the content of this activity to your scope of practice?			
Not at all	Somewhat	Mostly	Extremely

RETURN ANSWER SHEET TO

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CPD PORTAL: http://foh-cpd.co.za/cpd-online/cpd-user (Username: FOH number & Password: ID)

(Results are available immediately)

Email or **hard copy members**, complete your answer sheet online or return it to:

WHATSAPP: 074 230 3874 **EMAIL:** info@foh-cpd.co.za

(Results will be sent via email)

You will receive a confirmation of receipt SMS within 12-24hours, if not received please send again.

Have a suggestion or comment?

Send it to us on **EMAIL or WHATSAPP**